STATE OF CONNECTICUT

GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

REQUEST FOR PROPOSALS

The Department of Mental Health and Addiction Services on behalf of the Office of the Governor and the Connecticut Alcohol and Drug Policy Council (ADPC) invites proposals to develop science based, promising and innovative approaches to reduce and prevent substance use among Connecticut's youth ages 12 to 17. Preference will be given to proposals that utilize prevention programs that have been previously shown to lower substance use among youth. Since the goal of this initiative is to redirect Connecticut's prevention system toward effective, outcome based reductions in substance use, components of innovative programs should be grounded both in theory and empirical evidence. Although the reduction of substance use is the focus of this initiative, it is anticipated that other risky behaviors will also be reduced as evidenced by research. Collaboration among community service organizations is strongly encouraged.

Funding

Funds totaling $2.5 million will be available to support 15 to 25 grants for up to three years. Individual project awards are expected to range from $75,000 to $125,000 and will be distributed statewide to reach the broadest possible target population across the state. Funding will be available for three years starting December 1, 1999, with annual contract renewals based on satisfactory program performance, and availability of federal State Incentive Grant funds.

Eligibility

Connecticut's state agencies will be the only entities ineligible for funding under this grant. Proposals may be submitted individually or as part of a coalition, provided that applicants agree to collaborate with existing prevention-related organizations specified within the RFP.

Training and Technical Assistance

Comprehensive training and technical assistance will be offered by the State of Connecticut during July through September 1999, on needs assessment data, data application, science-based practices and programs, evaluation, collaboration/coalition building and grant writing.

Closing Date

Candidates seeking grant funds are required to submit an original and six copies of the completed proposals. These proposals must be received by 5:00 p.m. on Friday, October 1, 1999.

Place Due

Completed proposals must be sent to: Department of Mental Health & Addiction Services
410 Capitol Avenue, MS14PIT
Hartford, Connecticut 06134
Attention: Dianne Harnad, Project Director

Applicants' Conferences

Three applicants' conferences have been scheduled to answer questions on the RFP. They are:

CENTRAL REGION	DATE:	July 12, 1999
	TIME:	9:30 a.m. - 1:00 p.m.
	PLACE:	470 Capitol Avenue Conference Room C Hartford, Connecticut
SOUTHERN REGION	DATE:	July 13, 1999
	TIME:	9:30 a.m. - 1:00 p.m.
	PLACE:	Westport Town Hall Westport, Connecticut
EASTERN REGION	DATE:	July 15, 1999
	TIME:	9:30 a.m. - 1:00 p.m.
	PLACE:	Three Rivers Community-Technical College Mohegan Campus Norwich, Connecticut

Partners in the Development of the Governors Prevention Initiative for Youth

This Request for Proposal was developed in collaboration with the following state departments through a memorandum of understanding:

Department of Children and Families;
Department of Education;
Department of Public Health;
Department of Social Services;
Department of Transportation;
Office of Policy and Management;
Judicial Branch, Office of Alternative Sanctions; and the
Governor's Office.

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REQUEST FOR PROPOSALS

A. BACKGROUND/STATEMENT OF PURPOSE

The Governor's Prevention Initiative for Youth

During March 1997, in accordance with the President's National Drug Control Policy, the Secretary of the U.S. Department of Health and Human Services announced the availability of funds to states through a State Incentive Grant (SIG). The SIG agreement was part of a multi-year, shared, national Secretarial Initiative intended to: 1) mobilize and leverage substance abuse resources; 2) raise public awareness about substance use; and 3) measure outcomes. The purpose of these funds is to provide incentives for states to begin to effectively coordinate prevention resources directed at families, schools, communities and work places, in order to reduce substance use and related risk factors among adolescents between 12 and 17 years old.

The Department of Mental Health and Addiction Services, on behalf of Governor John G. Rowland and the Connecticut Alcohol and Drug Policy Council (ADPC), applied for and received one of these awards from the federal Center for Substance Abuse Prevention (CSAP). Connecticut's proposal, "The Governor's Prevention Initiative for Youth," was designed to carry out the recommendations of the ADPC, and the ADPC's prevention work of reassessing services for measurable results, and re-evaluating and re-configuring substance abuse prevention services within the state. Eight state agencies with prevention resources entered into a Memorandum of Understanding to coordinate, leverage and redirect these resources to support the Governor's Prevention Initiative for Youth and other related priorities included in the ADPC plan. The eight state agencies involved in this initiative include: The Department of Mental Health and Addiction Services, the Department of Education, the Department of Public Health, the Governor's Office, the Department of Social Services, the Department of Children and Families, the Office of Policy and Management, the Department of Transportation and the Judicial Branch. The additional federal funding will enable the development of programs that will target gaps in services, incorporate needs-based planning, implement science-based findings and best practices, and apply common outcome measures which will be used to assess effectiveness.

ADPC Statewide Interagency Substance Abuse Plan

The Governor's Prevention Initiative for Youth will build on and affirm the work of the ADPC's "1999 Statewide Interagency Substance Abuse Plan" and will serve as one of the primary mechanisms for advancing the implementation of the ADPC's substance abuse prevention recommendations.

A summary of the ADPC Prevention recommendations (Appendix A) includes:

- All state funded substance abuse prevention programs should be required to operate within the research-based prevention framework, and all State funded programs that seek to prevent other social epidemics should be integrated into the framework.
- All state funded substance abuse prevention programs should be held accountable to produce measurable results.
- Every municipality in Connecticut should have access to "core prevention services".

- Every community in Connecticut should have an adequately supported planning and advocacy initiative.

- Multi-year outcome-based contracts for prevention programs should be established.

- Establish commonly used outcome monitoring tools for the population as a whole and for program reporting.

Conceptual Framework: Prevention Principles

The Governor's Prevention Initiative for Youth aims to integrate the most promising prevention approaches identified by the federal Center for Substance Abuse Prevention (CSAP) and other prominent researchers into its revitalized comprehensive strategy. The National Institute on Drug Abuse's (NIDA) "Research-Based Guide to Preventing Drug Abuse Among Youth," points to several key principles and research-based programs, which have been adopted by CSAP, that will serve as the basis for The Governor's Prevention Initiative for Youth.

The conceptual framework for Connecticut includes the adoption of the following research-based principles:

1. Community-based programs will consist of components for the individual, family, school, media, health and community organizations;
2. Interventions will be carefully designed to reach populations at risk, with sufficient duration to make a difference;
3. Programs will be designed based on needs assessments, planning, implementation and review with feedback to and from the community;
4. Programs will employ media and public awareness strategies to solicit support, reinforce school based curricula, and keep the public informed;
5. Program components will be coordinated with other community efforts to reinforce prevention messages; and,
6. Programs will be developed based on gender, age, risk, and cultural appropriateness.

In its "Science-Based Practices in Substance Abuse Prevention: A Guide" (1999 Draft), CSAP has set forth additional considerations for adopting science-based principles. Among these considerations CSAP advises programs to employ both sets of principles as long as the logic behind how they work together is explained.

A summary of Key Science-Based Prevention Principles critical to the development of effective prevention strategies can be found in Appendix B.

B. STATEMENT OF PROBLEM

Substance abuse represents a significant public health and societal problem in Connecticut. Data from the *1997 Connecticut Substance Abuse Prevention Student Survey* conducted by the University of Connecticut Health Center, indicates several important trends in the state's school-age population. Recent use of marijuana, alcohol and cigarettes among 8th, 10th and 12th graders remains higher than the national average. Compared to a previous survey conducted in 1995, the 1997 survey reflected increases in:

recent illicit drug use among boys in grades 7 to 12; an increase in recent use of cigarettes by Latinos in grades 7 and 8; and, an overall increase in cigarette use among both boys and girls.

The survey also uncovered community conditions and parental attitudes supportive of substance use. Sixty-three percent of all the students surveyed reported that their families did not have clear rules around alcohol use. Sixty percent of all students reported that it was easy to get alcohol, and often obtained it from their home or from friends. These data reflect the need for clear, consistent rules and policies that are enforced, and the need for reduced availability around underage substance use in our communities. The Connecticut social service system provides well-documented evidence of the relationship between drug use and other problems such as domestic violence, delinquency and child abuse and neglect. Youth between 16 and 25, the products of drug abusing adolescence, swell the jails. In the 1995 Student Survey, substance abuse treatment was indicated for 52% of incarcerated youth at Long Lane School, 35% of juvenile arrestees, 19.8% of youth placed by the Department of Children and Families (DCF), 18% of dropouts and 24% of alternative students in alternative education programs.

Although past prevention programs have led to increased awareness of substance abuse, the trends uncovered by the statistics underscore the need to re-deploy prevention resources toward proven strategies that are effective in changing the knowledge, attitudes and behaviors of youth ages 12-17.

Realizing that state agency input was central to addressing the needs of the 12-17 year old population, a survey of state agency partners was conducted in May 1999 to determine what the needs for their constituents were. Among the interests identified were:

- Teacher trainings on science-based prevention programs and linking schools to community resources;
- After school programs;
- The need to strengthen families and increase their communication and improve the interaction between parents and child;
- More family focused programs;
- Innovative approaches to addressing problems among youth;
- Programs which target high-risk youth including Residential Student Assistance Teams; Strengthening Families; One-on-One Mentoring and Peer Group Counseling; and,
- Programs that target children at earlier ages.

C. SCIENCE-BASED SUBSTANCE ABUSE PREVENTION

Research shows that a single prevention strategy used in isolation cannot be effective in reducing substance use among youth. Instead, a combination of prevention strategies to decrease risk factors (situations and characteristics of individuals that increase the likelihood of substance use) and increase protective factors (those situations that decrease the likelihood of use) are most effective in preventing substance use among youth. Both risk and protective factors exist at every level, or domain, in which we interact with each other: peers, family, school and community.

In order to effect changes in youth behavior around substance use, communities must know the extent of the problem; decide exactly what it is they want to accomplish; identify the strategies they need to employ to reduce the problem and apply these strategies in the settings in which they work. In designing a comprehensive prevention project, applicants must consider the factors that have been identified as contributors to alcohol and drug use and incorporate strategies that will alter those factors. A summary

and selected findings from the DMHAS Substance Abuse Prevention Needs Assessment and Social Indicator Study can be found in Appendix E.

Additionally, a number of effective prevention/intervention approaches have been developed for use with the 12-17 year old population. A list of effective program models is included as Appendix D.

D. RESPONDING TO THE PROBLEM THROUGH THE GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

As described in the Background Section, the Governor's Prevention Initiative for Youth is predicated on a State-coordinated, community-based approach that brings the issue of teenage substance abuse to the level of the individual teen and those most important in his or her life. This approach is designed to change attitudes toward use, increase perceptions of harm and risk, and ensure that teens are receiving consistent "no-use" messages. Through the Governor's Prevention Initiative for Youth, communities will have the opportunity to enhance their capacity to reduce alcohol, tobacco, marijuana and other substance abuse at the local level.

Description of Services to Be Provided

In responding to this announcement, applicants are invited to submit proposals that develop and implement approaches that use science-based prevention strategies to reduce indicators of substance use in 12 to 17 year olds throughout Connecticut.

Proposals must reflect the overall goal of the Secretary's Initiative of reversing the upward trend and reducing recent use of marijuana by 25%, tobacco by 50%, alcohol by 20% and illicit drugs by 35% among 12-17 year old youth by 2002. This goal is consistent with the prevention direction outlined in the ADPC plan. Within this overall goal, the applicant should identify which risk/protective factor(s) and corresponding outcomes from Connecticut's Intermediate Outcomes: Baseline Risk & Protective Factors Chart (Appendix H), that will be addressed through their program. Applicants are required to submit detailed responses to the following:

1. Define the Community

Applicants must provide a definition of the community to be served (e.g., a defined geographic area such as a neighborhood, a municipality, schools or a community of interest such as a Latino community).

2. Define the Target Population

Applicants must define the target population to be served. The ultimate target population should be youth between 12 and 17 years of age. Applicants must identify risk and protective factors in their community, who they are trying to reach and the proposed best strategies to impact the selected target population.

Consistent with ADPC recommendations, and results from the DMHAS 1997 School Survey, suggested target groups include, but are not limited to:

- Children of substance abusers;
- Children who demonstrate early first use;
- High risk youth who exhibit other problem behaviors;
- Children with mental and/or anti-social behavioral problems;

- Children of parents in the criminal justice system;
- Children on the caseload of the Department of Children & Families;
- Children experiencing school failure or who have dropped out of school; and
- Children involved with the juvenile justice system.

In addition, programs may be designed to reach the general youth population between ages 12 and 17 without regard to individual risk factors. Applicants are strongly encouraged to review and utilize existing statewide, regional and local data in forming the basis for their comprehensive prevention program. As noted earlier, Appendix E provides a summary of the most important findings from DMHAS' 1997 School Survey and the Social Indicator Study.

Prevention efforts should be directed at the target population and those people who influence them including parents and their family members, peers, schools and their communities at large. In order to further define the target population, the following categories defined by the Institute of Medicine as classifications of preventive interventions (see Appendix F) should be used:

A. **Universal**: everyone in the general population such as all residents in a community, all students in a school or all people in a neighborhood.

B. **Selected**: specific groups within the general population who are at risk for developing a problem. Examples include: all seventh graders or students who are not achieving in school.

C. **Indicated**: individuals who are already exhibiting problems, such as youth who are experimenting with substances or exhibit other related behaviors such as truancy, aggression or violence.

3. Development of Project Plan

Applicants must develop a plan based on a comprehensive needs assessment of their community. The needs assessment process involves a comparison of population needs for services with existing resources to address those needs, as well as an assessment of the community's readiness to implement proposed interventions. Needs are indicated by the prevalence and incidence rates of alcohol, tobacco and other drug use, as well as the presence and levels of risk and protective factors among youth in the community. These needs may be either measured directly through survey data, such as school surveys, or indirectly through social indicator data. Applicants should look for existing data to support their needs statement. Local data is preferred but statewide or regional data reflecting appropriate data to the applicant's community. Community resources for substance abuse prevention include programs and other assets (e.g., personnel, funding, training and technical assistance) which exist or can be activated to reduce the likelihood that youth will begin or continue to use alcohol, tobacco or other drugs. These resources work to reduce risk factors or enhance protective factors that buffer the effects of risk exposure. The risk and protective factors to be impacted must be linked to the Connecticut Intermediate Outcomes: Baseline Risk & Protective Factors (Appendix G). The systematic assessment of needs and resources can assist applicants to:

- Assess particular needs for services in the community
- Identify appropriate strategies to address those needs
- Evaluate the match between prevention needs and existing resources
- Identify gaps in services

- Promote development of a comprehensive community-based prevention system.

Effective prevention programs are unlikely to be implemented if the community is not ready to accept and support the proposed intervention. The availability of existing resources to meet prevention needs is only one indicator of readiness. Readiness is also reflected in community attitudes toward the ATOD problem, toward prevention, and the level of support for the strategy being considered. Organizational characteristics of the community, including evidence of active and effective leadership, collaboration among agencies, and demonstrated ability to achieve prevention goals, are other key indicators of community readiness which should be addressed by applicants. Applicants are required to complete the "Community/Agency Readiness Worksheet" included in the application section of this RFP. This worksheet will be used to assess the community readiness and the applicants capacity to implement the proposed program.

To conduct a comprehensive needs assessment the applicant should:

- Examine the demographic composition of the target population or geographic area;
- Assess the incidence and prevalence of ATOD use and related problems in the target population;
- Identify existing behaviors or conditions within the target population or areas that predict ATOD use (e.g., risk and protective factors);
- Assess resources available to the population or in the area that can reduce risks and enhance protection;
- Assess the readiness of the population and agencies serving the population to implement the prevention strategies.

The applicant's intervention plan for a defined community should identify the dimensions of the ATOD problem among 12 to 17 year old youth, the risk and protective factors of this population, identified gaps in services, the strategies selected from the four focus areas (i.e., community, school, family and individual/peer) that will be used to address the problem, and community readiness to support the proposed intervention.

A well-defined logic framework will assist applicants in assessing whether strategies are working and intended outcomes are consistent with program design.

4. Define the Prevention Strategies and Program Model

It is essential to have buy-in from the people whose behavior you are trying to affect -youth ages 12-17. Youth should be included in any planning sessions, committees or coalitions that are going to make decisions directly affecting them. Similarly the diversity of gender, culture, ethnicity, religion, economic status and so on in the target group and those who impact them must be recognized and represented in the planning process.

Strategies are things people do to try to prevent a behavior such as substance use among teens. The Governor's Prevention Initiative for Youth is based on the premise that there is no one program or strategy that, in and of itself, can reduce alcohol and other drug use. **This grant requires communities to use multiple strategies in multiple domains.**

The Center for Substance Abuse Prevention has grouped prevention strategies into six basic categories: **information dissemination, education, substance-free recreation, early intervention, social policy and environmental change, and community and professional mobilization**. Within each category, a specific strategy may be considered to be "science-based" if it has been studied and shown to have an impact on risk and protective factors or substance abuse outcomes. A summary of science-based prevention strategies can be found in Appendix C. The ADPC has identified several system-wide and program-specific recommendations. Applicants are strongly encouraged to review Appendix A which summarizes these recommendations and incorporate them where applicable in development of proposed community-based prevention efforts.

5. Description of Prevention Model

Describe the prevention model selected for the program. There are several choices in this area: 1) Applicants may choose to take effective prevention models (see Appendix D) derived from rigorously controlled studies and adapt them in local community settings, with diverse populations, or replicate those proven to be effective in other populations and communities; 2) Applicants may build programs using those prevention principles (see Appendix B - Key Science-Based Prevention Principles) based on research and practical experience which have been critical to the successful development and implementation of prevention activities, or 3) Applicants may decide on innovative programs that are proposed to best meet the community's needs. These are novel interventions that are local, grounded in theory and have concrete indications of success.

All proposed programs and strategies will be assessed based on the following CSAP classification of types or degrees of rigor in science-based prevention efforts:

1. *Program has received public recognition awards;*
2. *Program/principle has appeared in publications or non-refereed journals;*
3. *Documentation of program/principles has been scrutinized in a peer consensus process or a paper appears in a refereed journal;*
4. *Program/principles subject to qualitative or peer-reviewed quantitative meta-analysis; and,*
5. *Successful replications of the program in other populations have appeared in several professional journals.*

Science-based programming is strongly emphasized and proposals containing programs that have enough evidence of effectiveness to be considered science-based (criteria 3, 4, and 5) will be weighted twice as much as proposals that are not science-based. See Appendix H for an explanation of Science-Based: Levels of Rigor.

6. Evaluation Plan

As a condition of the SIG funding, the Center for Substance Abuse Prevention (CSAP) requires that both state and sub-recipients participate in a statewide evaluation of the project. The state evaluation design is guided by a national evaluation framework (see Appendix I) developed specifically for the SIG to measure project activities and changes at the state, community and program levels. As a condition of accepting the

funds, applicants must submit a signed copy of the Assurance to Participate in the Evaluation (see application instructions) form as evidence of compliance with the evaluation requirements.

Researchers at the University of Connecticut Health Center are responsible for implementing and coordinating Connecticut's SIG evaluation, including the collection and analysis of the above-mentioned process and outcome data for the national evaluation. One of the objectives of the SIG is to develop sub-recipients' internal capacity for data collection and program evaluation. To that end, applicants are strongly urged to allocate sufficient staff (.25 FTE at minimum recommended) and resources, including computer equipment if necessary, for data collection and evaluation activities. Applicants will also be required to conduct a school survey among a representative sample of 7^{th} – 10^{th} grade students in the school district(s) served by the proposed program to directly assess the substance use and risk/protective factor profile of youth in the community. A school survey will be required in Years 1 and 3 of the project to assess community-level trends. The school survey and program evaluation instruments will be provided by the Evaluation Team, with opportunities to include additional items identified by sub-recipients at the community and program levels. The Evaluation Team will assist funded sub-recipients in selecting appropriate outcome measures, developing data collection protocols, and processing and analysis of data.

CSAP's evaluation requires *mandatory* collaboration with school superintendents within your program locale. As noted in Section III, Instructions to Applicants of this announcement, a letter of collaboration with the school system is a requirement for funding under this initiative.

7. Cultural Competence

Cultural competence refers to a system of policies, skills and attitudes that enable an agency or individual to provide services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning and communication style. Applicants must address cultural issues in the design and implementation of the proposed program and incorporate them with their coalition's organizational structure. Youth and families from diverse cultural groups present new challenges to providers in the community setting. Providers must be aware of basic principles of cross cultural service delivery, including the significance of culture as a factor in service interactions, the dominant cultural values common to specific populations, and the way in which program providers influence the delivery of services and attitudes toward the target population. For prevention efforts to be truly effective, diverse representation is needed early on at the program planning stage as well as throughout the implementation stage in order to appropriately respond to the culture of a target population. Applications will be judged on their commitment to cultural competence and ability to implement a culturally competent project.

8. Sustainment of Program Efforts

Applicants should describe how prevention efforts will be continued beyond the grant period and must develop and submit a long-term but flexible plan to do so. Applications must reflect an understanding that the program's delivery and outcomes is a shared responsibility among community, state and national organizations which requires a long term commitment and is flexible and adaptable to an ever changing environment. Mechanisms by which programs can build community involvement, ownership and commitment must be addressed in the design of the program.

9. Collaboration

Collaborative efforts among different community sectors (e.g., behavioral health, public health, education, children's health, business, faith, medical, law enforcement, etc.) have been shown to be effective in raising awareness about the issues of substance abuse and related problems and in coordinating prevention services.

For the purpose of this initiative, collaboration is expected to occur at the state, community and program level. At the state level, State agencies will coordinate prevention funding, including redirecting (as appropriate and legally permissible) state and federal funds. In addition, state agencies will develop and implement a comprehensive statewide prevention strategy focusing on youth ages 12 to 17.

At the community and sub-recipient level, applicants are strongly urged to partner with local providers (schools, prevention agencies, health departments, youth serving agencies, etc.) and businesses to coordinate and build on existing efforts. At the prevention program level, whether the focus resides in a small geographic area or specific target population, collaboration among key stakeholders is strongly encouraged. Exemplary prevention initiatives at the program level reflect an array of prevention activities (media campaigns, after and within school programs, parenting programs, etc.) coordinated with other public health or community programs where needs of the target population are solicited and met.

As part of this statewide collaborative effort, a number of resources have been identified within the state that can offer several methods of assistance. Applicants are advised to collaborate with the following agencies which may assist them with planning and coordination and/or training and technical assistance:

Department of Children & Family Regional Offices;
Regional Action Councils;
Drugs Don't Work!;
The ETP Center;
CT Institute for Cultural Literacy & Wellness;
Department of Children & Families Training Academy
Connecticut Asset Network
Connecticut Clearinghouse

Examples of additional collaborators could include:

School-Based Health Centers;
Family Resource Centers;
Police Chiefs;
Safe and Drug-Free School Coordinators;
Local Community Advisory Boards; and
Local Prevention Councils.

A summary of resources available that can aid in the development of a sound proposal can be found in Appendix J, entitled "Technical Assistance Resources." A listing and description of recommended collaborators can be found in Appendix K.

E. ELIGIBILITY

Proposals may be submitted from public or private organizations or agencies. Any combination of public or private agencies (with the exception of State agencies) may apply or applicants may apply as a single agency or as members of a group. In all cases, the applicant will be required to collaborate with school superintendents and principals and have their agreement to conduct a student survey within the schools in the targeted community. As previously noted, applicants are strongly encouraged to collaborate with law enforcement, local youth service bureaus, area juvenile courts and health departments and civic and recreation organizations within the community. Evidence of these collaborations must be documented in letters of commitment detailing the collaborator's specific role in the implementation of the program for the duration of the project, and will receive a higher specific rating in the application review process.

Proposals will be accepted from single applicants applying alone or group applicants. Group applicants may include coalitions, consortia or consist of as few as two entities. In the case of a group application, the applicant must provide evidence that they have been designated to act on behalf of the larger group. All applicants must reflect the diversity of community stakeholders in the planning process for their communities.

F. FUNDING

Approximately $2.5 million will be made available to support 15 to 25 awards under this RFP starting from December 1, 1999 to November 30, 2002. The size of the budget requests must show clear and obvious relevance to the realistic and financial needs of the proposal design. Applications which reflect in-kind contributions and/or cash match will receive additional points in the review. Consistent with CSAP guidelines, the majority of proposals funded will be science-based. A minimum of 60% of all sub-recipient funds are mandated to fund scientifically based prevention interventions (i.e., levels 3, 4 & 5) as defined in Appendix I under the CSAP's Science-Based Practices Guide's Levels of Rigor. Applicants should note that CSAP will be involved in the development of the final funding plan for the sub-recipients funded under this RFP.

SECTION II REVIEW CRITERIA

Proposals will be evaluated by a committee that will be established by the Department of Mental Health and Addiction Services with representatives from several State agencies. Applications will undergo three levels of review described below (See Appendix L for copy of the Application Review Format):

Level l
Once received, applications will be screened for completeness and compliance with instructions for submission. Applications which fail to include all required components will be deemed incomplete and removed from further review considerations. Criteria will include:

- completeness of application;
- compliance with submission procedures; and
- eligibility.

Level 2
Completed applications will be reviewed for technical merit by the review committee. Points will be awarded between 0 and 5 by each reviewer for each criterion, 0 being the lowest and indicating that a

criterion has not been met, and 5 being the highest where the criteria is met or surpassed. A weight has been assigned to each criterion as a measure of its importance. These weights have been predetermined. An application will be deemed competitive if it obtains at least 75% of the maximum allowable score under the technical review criteria. Criteria under this level will include:

- use of needs and resource assessments for the defined community;
- extent to which project uses science based prevention;
- realistic and measurable goals and objectives;
- appropriate program components/strategies to realize objectives;
- appropriate use of Logic Model;
- management and staffing plan/work-plan;
- clear and detailed budget;
- attention to evaluation.

Level 3
Applications recommended for approval based on their technical merit will be assessed based on the following additional criteria:

- applicant's prevention experience and organizational capacity; and
- documented support for project.

SECTION III INSTRUCTIONS TO APPLICANTS

A. APPLICATION SUBMISSION PROCEDURES

All applicants must use the attached application form for response to this Request for Proposal (RFP). An original and six copies, including appendices must be submitted. These must be submitted so that DMHAS can reproduce copies for reviewers. Applicants should not include anything that cannot be copied using automatic feed process. Excessive, oversized or odd-sized attachments must not be included. All attachments must be included on 8-1/2 by 11 inches white paper.

Applications must meet the following requirements:

- print on one side of standard 8-1/2 by 11 inch white paper that can be photocopied;
- use single spacing;
- use 1 inch margins for the top, bottom and side of the page;
- use 12 pitch font size;
- the name of the applicant must appear on the upper right hand corner of each page of the application;
- the application including the narrative and appendix pages must be numbered consecutively from beginning to end.

When received, an application will be screened for completeness and compliance with instructions for submission. An application will not be accepted for review and will be returned to the applicant if:

- the applicant organization is ineligible;
- it is received after the specified receipt date;

- it is incomplete;
- it is illegible;
- it does not conform to the application submission procedures;
- or it is not responsive to the program guidelines.

B. PROPOSAL CONTENT REQUIREMENTS

A completed application consists of the following components which must be listed in this sequence in the application's Table of Contents:

- *Connecticut's Governor's Prevention Initiative for Youth Sub-recipient Application* including:
  - Face Page
  - Table of Contents
  - Abstract
  - Logic Model Grid
  - Implementation Plan
  - Table of Organization
  - Community Readiness Worksheet
  - Budget Request and Justification

- Program Narrative
- Assurances
- Appendices, in the following order:
  - Project Implementation Plan
  - Letters of Commitment
  - Letter of Commitment from Superintendents regarding School Survey Participation
  - Literature Citations
  - Staff Resumes and Job Descriptions

a. Connecticut's Governor's Prevention Initiative for Youth Sub-recipient Application

i. The **Face Page** must be completed and placed on top of the application;

ii. The **abstract** must follow the table of contents. The abstract clearly represents a summary of the application and must not exceed the one page limit.

iii. The **Logic Model Grid** is included to assist applicants in conducting needs assessments and developing an implementation plan and indicates the changes expected to occur. Plans should be structured within the constructs of the logic model grid provided. A completed grid will contain the components of the applicant's plan that they expect to implement during the first year. Applicants must ensure that the grid is consistent with the *Connecticut Intermediate Outcomes: Baseline Risk and Protective Factors Chart* in Appendix G.

iv. The **Implementation Plan** should serve as a blueprint for coordinating and directing the tasks for the three years of the grant. It should describe the goals, objectives, tasks, staffing, and timeline. Taken together these components should describe all the tasks to be undertaken by the applicant in developing, implementing and evaluating the proposed program.

v. The **Table of Organization** must be completed for the proposed project and used to support the Management and Staffing Plan. The Table of Organization must reflect all staff, collaborators and supporters of the program, their relationship to each other and the percentage of time to the program.

vi. The **Applicant Community Readiness Worksheet** must be completed to assess the community's level of readiness to receive the grant and the applicant's capacity to implement the proposed program. A summary of resources available that can aid in the development of a sound proposal can be found in Appendix J.

vii. The attached **Budget Form and Justification** must be completed detailing any expected revenues such as cash matches, in-kind contributions, major costs such as personnel, operating and administrative expenses. The budget narrative must justify the information listed on the expense sheet and indicate any funding sources that will be merged with the grant funds.

b. Program Narrative

The program narrative should contain a complete and concise description of the proposed project. It must not exceed 15 pages and must contain the following:

i. Description of agency/coalition/consortium/ group and organizational capacity. Applicants must indicate whether they are a single applicant or part of a group and whether the project is community-based or statewide. If the applicant is a consortium or coalition, this must be described including the strengths and how long the group has been working together. Applicants must also provide evidence that they have the organizational capacity to carry out the proposed project including their resources, management and structure as well as the level of readiness for their communities to receive this grant (see required application forms).

ii. Description of the prevention plan for the community. This section of the narrative should be used to further explain the *Logic Model Grid* (see required application forms) and demonstrate how the strategies and programs chosen logically relate to the needs, goals and objectives. Applicants must include a description of the target population and community to be served, and the process used to determine the **needs, gaps and resources** and how the needs and gaps compare to Connecticut on a whole. **Risk and protective factors** must be identified and be consistent with the *Connecticut. Intermediate Outcomes: Risk and Protective Factors* document Appendix G. This section of the narrative should also describe: the overall **goals and objectives** of the plan and how it addresses the goal of reducing substance use among youth; how the goals and objectives will be reached through the **application of research based programs** and principles and the intensity and duration of the interventions. *(Research-Based Principles for Developing Alcohol, Tobacco and Other Drug Prevention Programs, Research-Based Program Models, and Science-based Practices in Substance Abuse Prevention: A Guide* are all documents that offer the most current thinking on science-based prevention). The plan must also reflect a commitment to **cultural competence** and describe how it will be addressed and how cultural inclusion will be assured in the implementation of the program. The degree to which

the applicant and community are ready to implement the program's interventions must also be described.

iii. Description of management and staffing plan. In this section, applicants must describe how the project will be organized, staffed and managed throughout the three year period. These functions must be delineated. A description of the staff, consultants or volunteers, whether they are full or part-time, and their experience and qualifications must be provided. Resumes should be provided in the Appendices.

iv. Description of Evaluation Plan. This section of the narrative should briefly summarize the plan to comply with statewide evaluation requirements and the outcome measures to be included in the evaluation of the program (must be consistent with *Connecticut Intermediate Outcomes: Risk and Protective Factors* - Appendix G).

v. Description of the plan for how grant efforts will be sustained at the end of the state funding cycle.

vi. Description of the collaborators and their role in the project.

c. Assurances

As a condition of submission, any prospective applicant must agree to adhere to the following conditions by signing the appropriate acknowledgments located in the application:

Conformance with Statutes - Any contract awarded as a result of this RFP must be in full conformance with the statutory requirements of the State of Connecticut and Federal Government.

Ownership of Proposals - All proposals in response to this RFP are to be the sole property of the State and subject to the provisions of Sections 1-19 of the Connecticut General Statutes (re: Freedom of Information).

Supplying Additional Information - The applicant shall agree to supply any additional information requested.

Stability of Budget - Any budget from applicant must be valid for a period of 120 days from the due date of the proposals.

Oral Agreements - Any alleged oral agreement or arrangement made by an applicant with any agency or employee will be superseded by the written agreement.

Amending or Canceling Requests - The state reserves the right to amend or cancel this RFP at its discretion, prior to the due date and time, and/or at any point prior to the issuance of the written agreement, if it is in the best interest of the agency and the state.

Rejection Default or Misrepresentation - The state reserves the right to reject the proposal of any applicant which is in default of any prior contract or for misrepresentation.

State's Clerical Errors in Awards - The state reserves the right to correct inaccurate awards resulting from its clerical errors.

Rejection of Proposals - Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.

Applicant Presentation of Supporting Evidence - An applicant, if requested, must be prepared to present evidence of experience, ability, service facilities and financial standing necessary to satisfactorily meet the requirements set forth or implied in the RFP.

Changes to Proposals - No additions or changes to the original proposal will be allowed unless specifically requested.

Subcontracting - In a multi-contractor situation, the state requires a single point of responsibility and accountability.

Regulatory Compliance - The applicant is required to be in compliance with any applicable provisions of the Regulations of Connecticut State Agencies and with State Non-discrimination and Affirmative Action laws, rules and regulations.

Participation in Evaluation - The applicant is required to work with the Connecticut Department of Mental Health and Addiction Services and evaluators from the University of Connecticut's Health Center's Department of Community Medicine to comply with the requirements of the statewide evaluation.

d. Required Applicant Appendices

Applicants must complete the following required appendices to support their applications (there is no page limit):

i. Any blueprint, framework or diagrams to illustrate the proposed program design;

ii. Additional Implementation Plan, Timeline and Milestones Chart;

iii. Letters of commitment spelling out the nature of the project contribution and involvement and tangible support by collaborators and supporters.

iv. Letter of collaboration with school superintendents stating their willingness to participate in the implementation of the school survey.

v. Literature citations must be provided including titles for all authors included in the literature cited in the application. Copies of journal articles, existing needs assessments and other research reports which support the chosen interventions must be included as an appendix.

CONTACT FOR ADDITIONAL INFORMATION

Questions concerning this RFP may be directed to:

Governor's Prevention Initiative for Youth
Department of Mental Health & Addiction Services
410 Capitol Avenue, MS#14PIT
Hartford, Connecticut 06134

Grant Line: (860) 418-6660

SECTION IV REFERENCES

Alcohol and Drug Policy Council, Statewide Interagency Substance Abuse Plan, *Submittal to Governor John Rowland and members of the Connecticut General Assembly*, January 1999.

Department of Mental Health and Addiction Services, CT Intermediate Outcomes: Baseline Risk & Protective Factors, 1999

Isaacs, M.R. & Benjamin, M., Towards a Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles 2. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1991.

Kentucky, State Incentive Grant Application and Guidance Document, 1998.

Kumpfer, K., "Individuals Strategies: What Works in the Prevention of Drug Abuse: Individual, School, and Family Approaches, *Secretary's Youth Substance Abuse Prevention Initiative Resource Papers*, March 1997.

Kumpfer, K., Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention-User Guide, *Office of Juvenile Justice and Delinquency Prevention*, September 1993.

National Institute on Drug Abuse, Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools, 1997.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Guidelines and Benchmarks for Prevention Programming Implementation Guide, 1999.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Science-Based Practices in Substance Abuse Prevention: A Guide, *Working Draft*, 1999.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Program Findings Sheet and Program Summaries, *Results of CSAP High-Risk Youth Study*, 1999.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Selected Findings in Prevention: A Decade of Results from the Center for Substance Abuse Prevention, 1999

Ungemack, J., Findings from the 1997 Connecticut Substance Abuse Prevention Survey, *compiled for The Connecticut Department of Mental Health and Addiction Services*, January 1999.

U.S. Department of Health and Human Services, Third Report to Congress on Alcohol and Other Drug Abuse Prevention: The National Structured Evaluation, 1994.

Vermont, State Incentive Grant Application and Guidance Document, 1998.

Washington, State Incentive Grant Application and Guidance Document, 1998.

State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

Request for Proposal Application

FACE SHEET

1.	**PROJECT NAME OR TITLE:**		
2.	**COALITION OR CONSORTIUM MEMBERS:**		
3.	**APPLICANT AGENCY** (*Legal name & address of organization as filed with the Secretary of the State*)	**TOTAL FUNDS REQUESTED** **FEIN #**	
4.	**CONTACT PERSON PROGRAMMATIC** *(Name)*	**TELEPHONE #**	**FAX #**
	TITLE	**INTERNET E-MAIL ADDRESS**	
5.	**CONTACT PERSON FISCAL** (*Name*)	**TELEPHONE #**	**FAX #**
	TITLE	**INTERNET E-MAIL ADDRESS**	
6.	**AREA SERVED** (*Check one)* ❑ Statewide ❑ Towns (List Below) ❑ Regions (List Below) ❑ Catchment Areas (List Below)		

I certify that to the best of my knowledge and belief the information in this application is true and correct. The governing body of the applicant has been duly authorized the document, the applicant has legal authority to apply for assistance, the applicant will comply with all applicable federal, state regulations and that I am a duly authorized signatory of the contract.

NAME	**TITLE**	**SIGNATURE**	**DATE**

State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

Request for Proposal Application

PROJECT TITLE: _____ APPLICANT NAME: _____

TABLE OF CONTENTS

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GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

Request for Proposal Application

PROJECT TITLE: _____ APPLICANT NAME: _____

ABSTRACT

State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

LOGIC MODEL GRID

Purpose: In order to assist in the development of your implementation plan, please format your plan within the constructs of the logic model.
Please use additional pages if necessary. If additional pages are used, number each subsequent i.e., 4a, 4b…etc.

Domains ⇩ / **Logic Model** ⇨	**Needs Assessment** • **Substance Use** • **Risk/Protective Factor** • **Resources/Assets** • **Readiness** **(Problem Statement)**	**Risk/ProtectiveFactor(s) (Goals)** • **Target Population** • **IOM Program Classification**	**Objective(s)**	**Identify Categories of CSAP Strategies**	**Model Program/ Methodology**	**Activities that Enhance Protective Factors**	**Outcome Measures**
Peer/Individual							
Family							
School							
Community							

State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

IMPLEMENTATION PLAN

In the spaces provided, please indicate your program's goal(s) and corresponding objectives, and activities, the staff person responsible for carrying out those activities, and timetable for completion. ***Complete a separate page for each goal and label the pages alphabetically (eg. a, b, c, etc.).***

GOAL #:

Objective	Activities	Staff Responsible	Time Table

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GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

TABLE OF ORGANIZATION

State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

COMMUNITY APPLICANT READINESS WORKSHEET

1. Documentation of Need

a. Has your organization or coalition conducted a needs assessment or used existing data on the substance abuse problem in your community to assess needs and gaps in services? ❑ Yes ❑ No

b. If so, when was it completed?
_____

c. What are the results?
_____
_____
_____
_____

2. **Vision and Resources**

a. Describe your agency's or coalition's vision for combating substance abuse in your community. _____
_____
_____

b. What resources exist including strengths and assets in your community to help you realize that vision?_____
_____
_____
_____
_____

3. Community Awareness

a. What is the nature and scope of the problem as your organization perceives it? _____
_____
_____
_____

4. Organization/Coalition's Approach to Address Issues

a. What methods has your organization or coalition used to combat these problems in the past? _____

_____

b. Please list your successes and failures.

_____

_____

_____

_____

_____

_____

5. Funding History

a. Have you sought and received funding for programs to address the problems uncovered by your community's needs assessment? ❑ Yes ❑ No

b. If so, what were the sources of funding? _____

_____

c. What were the services provided? _____

_____

_____

_____

_____

6. Networking

a. What groups or organizations have you networked with to address issues in the past?

_____

_____

_____

_____

b. Who will you network with in the future? _____

_____

_____

_____

_____

_____

_____

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

BUDGET REQUEST

Fiscal Year 1999/2000 - Year 1

Budget period: From: December 1, 1999 - November 30, 2000

Categories	Governor's Prevention Initiative for Youth Funding	Other Match Funding *(identify source)*	In-kind Funding	Total
Personnel				
Fringe Benefits				
Consultants				
Operating Costs: Postage Supplies Telephone Printing Equipment Advertising/Marketing Materials Educational training Professional Liability Insurance Meetings and Conferences Evaluation (15% of Total Budget)				
Travel				
Occupancy: Rent Utilities Insurance Repair and Maintenance				
Total				

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

BUDGET REQUEST

Fiscal Year 2000/2001 - Year 2
Budget period: From: December 1, 2000 - November 30, 2001

Categories	**Governor's Prevention Initiative for Youth Funding**	**Other Match Funding**	**In-kind Funding**	**Total**
Personnel				
Fringe Benefits				
Consultants				
Operating Costs: Postage Supplies Telephone Printing Equipment Advertising/Marketing Materials Educational training Professional Liability Insurance Meetings and Conferences Evaluation (15% of Total Budget)				
Travel				
Occupancy: Rent Utilities Insurance Repair and Maintenance				
Total				

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

BUDGET REQUEST

Fiscal Year 2001/2002 - Year 3
Budget period: From: December 1, 2001 - November 30, 2002

Categories	Governor's Prevention Initiative for Youth Funding	Other Match Funding	In-kind Funding	Total
Personnel				
Fringe Benefits				
Consultants				
Operating Costs Postage Supplies Telephone Printing Equipment Advertising/Marketing Materials Educational training Professional Liability Insurance Meetings and Conferences Evaluation (15% of Total Budget)				
Travel				
Occupancy: Rent Utilities Insurance Repair and Maintenance				
Total				

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

BUDGET JUSTIFICATION

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

PROGRAM NARRATIVE

(Pages 10-24)

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH

PROJECT TITLE: _____ APPLICANT NAME: _____

ASSURANCES

As a condition of submission, any prospective applicant must agree to adhere to the following conditions by signing below:

Conformance with Statutes: Any contract awarded as a result of this RFP must be in full conformance with the statutory requirements of the State of Connecticut and Federal Government.

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Subcontracting: In a multi-contractor situation, the state requires a single point of responsibility and accountability.
Regulatory Compliance: The applicant is required to be in compliance with any applicable provisions of the Regulations of Connecticut State Agencies and with State Non-discrimination and Affirmative Action laws, rules and regulations.

Participation in the Evaluation: The applicant is required to work with the Connecticut Department of Mental Health and Addiction Services and evaluators from the University of Connecticut's Health Center's Department of Community Medicine to comply with the requirements of the statewide evaluation. The requirements include, but are not limited to, the following:

Participate in a rigorous evaluation including process and outcome assessments as described in the RFP and must cooperate with the following statewide requirements at the community and program levels.

- Work with the evaluation team to finalize an evaluation plan that includes 1) a statement of goals. objectives and action steps to achieve objectives, 2) identified survey items, 3) strategy for obtaining parental consent. 4) strategy for recruiting and training volunteers to administer the youth survey. 5) procedures for collecting process and outcome data, and 6) timetable of activities.

- Participate in meetings to develop an implementation and evaluation plan.

- Conduct a School-Based Youth Survey of 7th through l2th graders in school districts served by the proposed program to directly assess the substance use and risk and protective factor profile of youth in the community. This survey will be required in years 1 and 3 of the project to assess community-level trends.

- Document and submit the activities, strategies and participant characteristics of the program.

- Assure that collaborators, supporters and project staff will be available to be surveyed or interviewed, as necessary, to ascertain progress and evaluate issues regarding program implementation and outcomes.

- Interview or survey project participants before and after program interventions to monitor program outcomes.

- Participate in a Project Director and Community Resource Assessment Survey to measure sub-recipient characteristics and community readiness.

Signature of Authorized Official	Title
Agency/Organization	Date

The State of Connecticut
GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH
RFP APPLICATION INSTRUCTIONS

PROJECT TITLE: _____ APPLICANT NAME: _____

INSTRUCTIONS FOR FACE SHEET

Section 1: Indicate the title of your proposed program.

Section 2: If this is a group application, list all the agency members.

Section 3: Name and address of organization designated to receive funds (fiduciary agent) as filed with the Secretary of State's Office. Provide Federal Employer Identification Number (FEIN) and total funding requested.

Section 4: Name, title, telephone number, Internet e-mail address (if available), and fax number of programmatic contact person.

Section 5: Name, title, telephone number, Internet e-mail address (if available), and fax number of fiscal contact person.

Section 6: Check the geographic area served by the proposed program. If catchment area(s), towns or regions list all that apply.

A person who is authorized by the Applicant's Governing Body to apply for funds must sign applications. This should be the same person who will sign the contract.

INSTRUCTIONS FOR PAGE 2 - TABLE OF CONTENTS

Provide a Table of Contents outlining the sections of the Application and the related pages.

INSTRUCTIONS FOR PAGE 3 - ABSTRACT

Provide a summary of the proposed program including a clear description of the goals, targets, approaches, linkages and outcomes. The abstract must not exceed the one page limit.

INSTRUCTIONS FOR PAGE 4 - LOGIC MODEL GRID

Logic Model Summary

Applicants should use the Logic Model proposal form to create a project blueprint. The organization of this form provides justification for your program and shows the logical development of the project plan from needs assessment through selection of the intervention(s). Applicants should summarize their narrative responses on the forms. Forms should be filled out for each target audience.

Needs Assessment/Problem Statement

A **needs assessment** answers the question, "What kinds of substance abuse problem(s) does this community have? A complete needs assessment will identify:

1. What substances are being used in the community, by whom and in which situations;

2. What are the risk & protective factors associated with substance use in the communities; and

3. What programs and services already exist to address this problem, their utilization and accessibility.

The purpose of the problem statement is to translate the needs assessment data into realistic statements that identify the kinds of problems being addressed based on resources available.

In your problem statement make sure the target population is identified, root problem is described, and not just the symptom(s).

Risk/Protective Factor(s) Goal(s)

Example of a Goal: Youth make a commitment to abstain from illegal use of alcohol, tobacco and other drugs.

Objectives should:

- Identify results (behavior, attitudes and/or knowledge) or conditions to be achieved rather than activities to be performed.
- Be time-specific, such as by "March 2000".
- Be stated in terms of what change is expected rather than in the terms of what is to be avoided, such as a specific increase in social skill competency.

- Be designed to cover a single end result.

- Be written in measurable terms, for example, 15% reduction of positive attitudes towards drug use.

CSAP Categories of Strategies

Prevention strategies can be grouped together in a variety of ways. CSAP promotes the following 6 categories:

- Information Dissemination*
- Education
- Substance Free Alternative Activities*

- Problem Identification & Referral
- Public Policy & Environmental Change
- Community-Based Processes

Choose the category of strategies you feel is best suited to achieve your program.

*Neither of these categories alone has been shown to be effective at preventing substance abuse.

Model Program/Methodology (Refer to Appendix D for a list of models)

You have chosen from a listing of science-based model programs and strategies to address your community's needs. The question you must now ask yourself is: "Will the model program, methodology or intervention strategies we have chosen address the risk/protective factor(s) we have selected and achieve the outcomes we desire?"

Activities that Enhance Protective Factors

Activities are the actions that will take place within the coalition and with the participants in your model program(s)) that will enable the changes you desire to happen. Activities should be designed to enhance the protective factors in your community, in addition to reducing chosen risk factors.

Outcomes

Outcome measures are used to assess whether an objective has been accomplished.

Indicate any information or evidence you will use to determine the extent to which the objective will be achieved.

INSTRUCTIONS FOR PAGE 5 - IMPLEMENTATION PLAN

This plan must be consistent with the Logic Model Grid.

Goal: Specify each goal of your program(s).

Objective: Specify the objectives which correspond to the goal.

Activities: List all major activities needed to fulfill each objective. It may be necessary to use more than one page. Activities are specific tasks required to accomplish the objectives.

Staff Responsible: Indicate the staff responsible for the completion of the activities and/or objectives.

Time Frame: Indicated specific time frames for completion of each activity/objective.

INSTRUCTIONS FOR PAGE 6 - TABLE OF ORGANIZATION

Chart how the project will be organized including all staff, collaborators and supporters of the program, their relationship to each other and the percentage of time dedicated to the program.

A description of staff positions and resumes must be included in the appendices.

INSTRUCTIONS FOR PAGES 7a-b – COMMUNITY READINESS WORKSHEET

Complete the questions to assess your community's level of readiness to receive the grant.

INSTRUCTIONS FOR PAGES 8a,b,c – BUDGET REQUEST

Applicants must use the budget request form in completing a three-year budget proposal. The budget should be divided into five major categories of cost: personnel, fringe benefits, operating, travel, and occupancy. Revenues should be listed, and sources identified. In addition to completing the budget forms, you must supply a narrative for your budget. The narrative should justify specific items listed in the budget request forms. In developing your budget plan, consider cost for personnel, meetings, and trainings, coalition development, evaluation, and internet access, etc.

INSTRUCTIONS FOR PAGE 9 – BUDGET JUSTIFICATION

The budget narrative should include: justification for the budget costs as well as any funding sources that will provide a cash match with the State Incentive Grant.

Indirect Costs

Explain the basis for the overhead fee charged by the fiscal agent (regardless whether that agent is the applicant, one member among the group of applicants, or an outside entity hired by the applicants(s). Specifically describe what services are received by the project in return for the fee.

INSTRUCTIONS FOR PAGES 10-24 – PROGRAM NARRATIVE

Provide a complete and concise description of the proposed project. The narrative pages must be: numbered consecutively; contain the names of the project and applicant; and, must not exceed 15 pages. The narrative description must be consistent with Section III, B; subsection b "Program Narrative" of the RFP. Note that narrative may be less than the 15 pages alloted.

INSTRUCTIONS FOR PAGES 25a,b – ASSURANCES

Application must include a signed copy of the assurances indicating adherence to the conditions outlined.

INSTRUCTIONS FOR REQUIRED APPENDICES

Applicants must complete the following required appendices to support their applications in the following order. There is no page limit for these appendices.

i. Any blueprint, frameworks or diagrams to illustrate the proposed program design;

ii. Letters of Commitment spelling out the nature of the project contribution and involvement and tangible support by collaborators and supporters;

iii. Letter of collaboration with school superintendents stating their willingness to participate in the implementation of school survey;

iv. Literature citations must be provided including titles for all authors included in the literature cited in the application. Copies of journal articles, existing needs assessments and other research reports which support the chosen interventions must be included as an appendix.

APPENDIX A

SUMMARY OF ADPC PREVENTION COMMITTEE RECOMMENDATIONS

PREVENTION COMMITTEE RECOMMENDATIONS

A. OVERALL SYSTEM-WIDE POLICY RECOMMENDATIONS

✓ Assure that all State funded substance abuse prevention programs operate within the research-based prevention framework, and integrate State funded programs that seek to prevent other social epidemics into the framework. These other issues include, but are not limited to, youth crime and violence, teen pregnancy, and school dropouts.

✓ Inform/train all programs of best practice standards as identified through research and provide training and technical assistance to the programs to meet these standards. Create a local reporting system to the State to monitor program outcomes, which includes a "minimum data set"[1] to evaluate the effectiveness of individual programs and the State's system of services.

✓ Establish multi-year outcome-based contracts for prevention programs to allow an adequate amount of time to implement programs and evaluate preliminary program results. Assure that all State funded substance abuse prevention programs are held accountable to produce measurable results through commonly prioritized intermediate outcomes across State agencies.

✓ Build the evaluation capacity within the State and evaluate existing services to determine duplication, gaps in types of services and in populations and/or regions, so that funds are used effectively. Also, refocus and modify existing services, as needed.

✓ Establish a commonly used outcome monitoring system for the population as a whole. Assure that available prevention research is more widely disseminated to policy makers, funders and program developers at the local, regional and state levels. A regular system of following population-based substance abuse and related trends in the state must be established to monitor emerging issues, i.e. continued drop in age of initiation of harmful substance use.

✓ Assure that every town in Connecticut has access to "core prevention services" with an initial prioritizing of services that will impact youth and their families. Core services are defined as the full spectrum of strategies at all levels: family, school, community, and individual/peer.

✓ Develop and enhance, using existing resources to the extent possible, an initiative to assure that every community in Connecticut has an adequately supported planning and advocacy effort, mobilizing the assets and resources of the community. The local initiatives should include key representatives of the schools, police and others, to focus attention on and implement actions to reduce substance abuse.

B. PROGRAM IMPLEMENTATION RECOMMENDATIONS

Focus Area: Family

✓ Significantly expand prevention efforts for parents by encouraging existing youth targeted programs to include a family component, as appropriate.

[1] A minimum data set should include information describing types and frequency of services, program and target population characteristics, number served and data on intermediate outcome(s).

- ✓ Infuse and link effective family prevention programs focused on other problems, if necessary, with substance abuse prevention strategies, and develop a partnership with adults and parents who are involved in existing community youth-focused programs (e.g. volunteer sports leagues, religious organizations, PTO/As).

- ✓ Increase emphasis on families (parents and their children) by piloting or expanding a best practices program, such as one existing in state or a nationally recognized model not yet available in Connecticut, e.g. FAST (Families and Schools Together Program).

Focus Area: School

- ✓ Increase the number of after-school programs being offered by schools to engage students in positive, bonding opportunities.

- ✓ Increase peer-to-peer and youth-led efforts linked to the schools.

- ✓ Create a comprehensive drug education program in the schools for youthful first offenders that includes adequate early intervention to address the many needs for these students.

Focus Area: Community

- ✓ Create two or three pilot sites for the teen court program to respond to early stage drug offenses (e.g. purchasing alcohol, DWI, violating school drug policy, etc.).

- ✓ Increase emphasis on efforts that take a social policy approach (policies that change norms of behavior) to issues such as youth access to tobacco or alcohol and inconsistent enforcement of laws.

- ✓ Establish multiple rites of passage initiatives to enable participants at the community level to develop, implement and sustain partnerships through orientation, training and other widely accepted community development techniques used in various recognized rites of passage strategies.

- ✓ Consider increasing support for local organizations to provide technical assistance to implement best practices into community based programs.

- ✓ Build the capacity of social institutions other than schools and families (e.g. churches, community centers, YMCA/YWCA) to provide individuals with opportunities to develop personal capacities as well as opportunities for interaction in constructive endeavors with peers who behave appropriately.

- ✓ Establish and/or build on health promotion campaigns, that serve to raise a community's awareness of the prevalence of ATOD use among youth and adults, aimed at systematically reaching community members and encouraging them to become active in prevention efforts.

Focus Area: Individual, Peer

- ✓ Create a systematic approach to delivering prevention services to high risk youth[2], especially for abused and neglected children, and link prevention and treatment by targeting both at risk (e.g. low income) youth and other persons, as needed. Prevention, early intervention and treatment will be coordinated under a

[2] In addition to young DCF clients, include other children of adults on the caseload, or incarcerated, in such agencies as DMHAS and Judicial Branch's Office of Alternative Sanctions (OAS), Court Support Services.

comprehensive system through referrals and other methods of identifying people who are substance dependent or abusers.

✓ Improve coverage of screening and early intervention for all groups statewide. A next step is expansion of these services in the schools , e.g. increased school-based early intervention programs and groups for early stage (non-dependent) substance abusers and children of addicted parents.

✓ Establish additional programs providing "positive youth development" services. These programs, that interrupt problem behavior at the most timely point, currently serve only 30 percent of the towns in the state.

✓ Increase the number of programs for children of substance abusing parents, offering clinical preventive services to middle school-aged children. They currently exist in three of the five uniform regions established for State human service agencies, and there is a need to make them available in all five regions.

✓ Increase resources available for mentoring and programs that include promotion of life and social skills, or development of positive relationships with adults.

✓ Encourage statewide use of available funding for the Drug Enforcement Program through OPM.

✓ Expand summer programs for youth by reaching more youth in the14 priority school districts and providing services in other cities with many high-risk youth.

✓ Expand youth centers in additional neighborhoods in suburban and urban areas.

✓ Expand respite programs for families and extended families.

C. INFRASTRUCTURE CAPACITY RECOMMENDATIONS

All Levels (State, Regional and Local)

✓ Provide support, e.g. training and technical assistance, to assist programs in the implementation of the research-based outcome standards.

✓ Provide culturally appropriate services to all populations served.

✓ Increase the visibility of substance abuse prevention services through publicity and social marketing techniques to increase utilization.[3]

✓ Inventory the many substance abuse prevention services that are privately funded (e.g. United Way) and develop a public/private partnership for prevention planning and implementation.

✓ Target, when appropriate, specific harmful substances and link efforts with existing projects focused on underage alcohol and tobacco use, funded by the Robert Wood Johnson Foundation.

State Level

[3] Use various approaches, such as expanding corporate media support and incorporating the issue in Connecticut's annual Family Day in September.

- ✓ In the first year of plan implementation, emphasize programs that primarily focus on youth substance abuse prevention. The State Incentive Grant noted earlier is limited to youth and will be a major focus of plan implementation.

- ✓ Designate staff to continue data collection and tracking work related to services available, including implementation of standards, evaluation of outcomes, and integration at the local and community level.

- ✓ Expand the scope of work in future years to other age groups and to enhance coordination with those programs, which provide substance abuse prevention strategies as a secondary focus, e.g. dropout prevention.

- ✓ Plan systematically and coordinate all prevention resources within State government.

Regional Level

- ✓ Improve integration of regional and local infrastructures funded by different State agencies, such as better linking Regional Action Council (RAC) and Local Prevention Council (LPC) processes, to name a few.

- ✓ Consider expanding the RAC funding base to perform required functions, e.g. standardized needs assessment.

- ✓ Improve the effectiveness of the regional component of the infrastructure, if possible, by utilizing the regional level of resources available through the uniform human services regional system. Examine the effectiveness of regional structures in other states.

- ✓ Implement statewide coverage of Regional Action Councils (RACs) by operationalizing the RAC in the greater New Haven area, raising this RAC to the full level of current funding, and provide funding for the RAC in northwestern part of the state.

Local Level

- ✓ Establish research-based outcomes in existing substance abuse prevention programs and evaluate the implementation through local programs.

- ✓ Have local programs participate in the support system for the evaluation by utilizing training and technical assistance to help in the implementation of the research-based outcome standards.

- ✓ Encourage statewide use of available funding for local councils and consider continuing to provide impetus for increased community and parent involvement and action.

- ✓ Determine if additional emphasis, through increased program funding, is needed in suburbs and rural communities.

- ✓ Expand the availability of community service opportunities for youth.

APPENDIX B

KEY SCIENCE-BASED PREVENTION PRINCIPLES

Principles of Successful Prevention Programming

1. Comprehensive
    - ❖ Planned intervention is designed to address risk and protective factors in the primary domains of influence (e.g., families, schools, peers, community, media) (Hawkins et al. 1992; Kumpfer and Turner 1990/1991; Perry et al. 1993).
    - ❖ Focus on changing the social environment (Lewis et al. 1990) such as families, communities, and schools, to create an enduring effect.
2. Research-based and theory-driven
    - ❖ Effective prevention programs are based on multicausal models, generally biopsychosocial theories (Kumpfer et al. 1990) that have been empirically tested and found appropriate for the targeted population (Kumpfer 1989; Kumpfer and Turner 1990/1991).
    - ❖ Prevention programs should target the causes of the unwanted behavior (Hawkins and Catalano 1993; Thornberry et al. 1994).
3. Tailored to participants' needs
    - ❖ Services should match the identified needs of potential participants (Ramey and Ramey 1992).
1. Relevant
    - ❖ Prevention programs are more effective in recruitment, retention, client satisfaction, and effectiveness when they are designed specifically to be relevant by culture, gender, development, and geography.
2. Appropriately intensive
    - ❖ The more causal factors or processes to be addressed, the more intensive the programming should be.
3. Appropriately timed
    - ❖ The program should be in place early enough to have an impact in changing the developmental trajectory of the problem (Werner 1989).
4. Supportive
    - ❖ Prevention effects decay over time without booster sessions or some type of reminders of the skills learned. Therefore, follow-up sessions that are developmentally appropriate are needed (Dusenbury and Falco 1995).
5. Focused on skills development and behavior change
    - ❖ Active, hands-on experience increases participants' skills, even when training the staff (Lerner 1995).
    - ❖ Interactive teaching methods of substance abuse education are more effective than didactic methods (Tobler and Stratton in press).
6. Inclusive of participants with more pro-social role models
    - ❖ Effective prevention programs do not isolate high-risk or indicated problem youth without adequate supervision and expect group norms to become more positive. Rather, they provide opportunities for a few high-risk youth to socialize with youth with more healthful norms, attitudes, and skills.
    - ❖ Change the norms of the group to more healthful norms and values, or clarify that the actual norms are more traditional than most youth believe (Perkins and Berkowitz 1992).

(For additional discussion on science-based principles, consult "Science-Based Practices in Substance Abuse Prevention: A Guide" in Section IV – References of this RFP packet.

APPENDIX C

SUMMARY OF SCIENCE-BASED PRINCIPLES STRATEGIES

SUMMARY OF SCIENCE-BASED PREVENTION STRATEGIES

As prevention practitioners deciding to implement prevention programs in your schools, communities, clinics, agencies, or other settings, it is critical to identify and adapt science-based strategies that are likely to be most effective in meeting the needs of the people with whom you work. When you base your program on a set of strategies proven effective through rigorous evaluation, you increase the likelihood that you will reduce substance abuse. Yet, how do you determine which strategies work?

The program evaluation literature is dense and there are hundreds of programs to review. The review process is complicated by the fact that some rigorously evaluated programs are shown not to work; many programs use weak evaluation designs, making it impossible to draw conclusions about their effectiveness; and many more programs have not been evaluated. The prevention field is working currently to identify programs that meet various sets of criteria that define what is science-based.

Replicating a "packaged" science-based program is one approach to meeting prevention needs. While replication has many advantages, there are some potential pitfalls you should consider. These include:

- The programs available may have been designed, implemented and evaluated with audiences and in settings different than your own.

- The programs available may not meet the needs you have identified as priorities for the population you serve.

- The programs, if comprised of multiple strategies, may include some strategies that work better than others at achieving the desired outcomes.

- It may not be feasible to implement the program as intended due to constraints related to resources and setting.

If you cannot find a packaged, science-based program that matches your specific audience issues, then consider:

- adapting one of your funder-identified programs; or
- developing a new program

Adapting or developing programs that use various strategies or components as the building blocks of the program design allows you to create a program that better meets the needs and draws upon the assets of the people you serve. When you base your program on a set of strategies proven effective through rigorous evaluation, you increase the likelihood that your program will be effective in reducing substance abuse. However there are no guarantees; and, you assume greater risk when designing your own program than you would replicating another. So, how do you increase the likelihood that your program will be a success?

Fortunately, researchers at the national level have made great strides in distilling effective strategies and principles from the multiple programs that focus on preventing and reducing substance abuse and related risky behaviors. It is important that you view these strategies, like the work from which they are derived, as a work-in-progress; that is, the strategies we describe below represent only what is known currently about what works. For every strategy evaluated, there are others that remain untested.

To increase the probability that your adapted or new program will be successful, the Northeast CAPT has compiled the following information on science-based strategies drawn in large part from the Center for

Substance Abuse Prevention's (CSAP's) Science-Based Practices in Substance Abuse Prevention: A Guide. This document describes science-based strategies in seven major areas:

- Policy •Enforcement •Communications •Education •Collaboration •Alternatives
- Early intervention

These strategies for preventing substance abuse are, in many cases, parallel with those for violence prevention. While there is no guarantee that a prevention activity based in these principles will succeed in delivering positive outcomes, these key elements can provide a solid foundation for a science-based approach.

GENERAL GUIDELINES FOR PREVENTION PROGRAMMING

Research suggests some general guidelines that you can follow before you begin to think about which specific strategies to adopt. These include:

- Developing an understanding of the underlying causes of or factors that contribute to substance abuse and the strategies that can affect those factors.

- Identifying carefully those risk factors most closely related to the substance abuse problems you have identified.

- Selecting prevention strategies that sound research has shown are effective.

- Conducting continuous, rigorous evaluation to determine whether you have met your goals and objectives.

In addition, keep the following points in mind when developing your program:

- Drawing upon multiple strategies to meet one common goal increases the likelihood of program effectiveness. (For example, community X's goal is to curb underage drinking. Therefore, all of the strategies they decide to employ should ultimately point to achieving this goal. Some of the strategies they will use to reduce access to alcohol include sting operations, merchant education programs, and the development of local ordinances around the location of alcohol vendors aim. Other strategies target the individual behavior of youth through peer education programs and life skills training.)

- The use of many strategies or principles does not necessarily guarantee greater program effectiveness. It is most important that strategies are coordinated to work towards the achievement of one goal.

- Applying science-based strategies to a poorly designed and implemented program may improve outcomes, but it will not guarantee an effective program.

- Strategies should complement one another to avoid any counteracting effects (For example, adopting a clear school policy concerning substance use with clear sanctions can help to reinforce educational programs in the classroom.)
- Some strategies are more potent than others in preventing substance abuse and violence.

- Innovative prevention strategies that may have little or no evaluation data can be used, as long as you include a rationale for their inclusion and a plan for their evaluation.

POLICY STRATEGIES

Perhaps the most potent strategies for preventing, reducing, or eliminating substance abuse (and violence) are the creation, promotion and enforcement of policies and norms designed to change the environments in which people live and work. Policies include laws, rules, and regulations that serve to control availability of alcohol, tobacco, and other drugs through pricing, deterrence for using or incentives for not using, restrictions on availability, and restrictions on use. Policies also codify norms about substance use and specify sanctions for violations. Governments (municipal, state, and federal levels), public agencies (e.g., police departments, school systems), and private organizations (e.g., HMOs, hospitality establishments, convenience stores) all institute policies.

Policy strategies are more likely to be effective if they:

- Are paired with collaboration and communications strategies. Regulations must be in step with community norms, beliefs about the harmfulness of a particular substance or the "rightness" or "wrongness" of a particular action. For a community to move on a particular policy or regulation, it must understand the problem and be ready to make changes based on that understanding.

- Increase the price of alcohol or tobacco. Increases in price through excise taxes have been associated with effectively reducing consumption—the number of people smoking cigarettes and drinking alcohol and the amount of alcohol and tobacco consumed. This strategy can also reduce various alcohol-related problems, including the incidence of motor vehicle fatalities, driving while intoxicated, rape, robbery, and suicide and cancer death rates.

- Set the legal blood alcohol content (BAC) limit to 0.08. Research shows that BACs at this level or lower are associated with reductions in levels of impaired driving and alcohol-related crashes. Revoking drivers' licenses in the event of an illegal BAC or if the driver refuses to be tested has been shown to reduce the number of fatal crashes and repeat offenses among DUI offenders.

- Set the legal blood alcohol content (BAC) limit to 0.00 or 0.02 for young people under the age of 21. When paired with a variety of driving restrictions (e.g. graduated driver's licensing) that are gradually lifted as the driver gains experience, this strategy has been shown to significantly reduce traffic deaths among young people.

- Provide deterrents to using alcohol or firearms or incentives for not using. Suspending the driver's license of a person under 21 years of age following a conviction for any alcohol or drug violation is an effective way of increasing compliance with minimum purchase age laws among the young.

- Limit the location and density of alcohol retail outlets. This strategy may help contribute to reductions in alcohol consumption, traffic crashes, and certain other alcohol-related problems, including assaults. Using this strategy can contribute to a reduction in the availability of substances to youth.

- Restrict the use of tobacco in public places and private workplaces. Restricting use has been shown to be effective in reducing cigarette sales and tobacco use, lowering average daily cigarette consumption among adults and youth.

ENFORCEMENT STRATEGIES

Consistent enforcement and reinforcement is needed to enhance the effectiveness of existing as well as new policies regarding substance abuse. Police officers, in particular, are important to enforcement, and as such, should be represented on your community advisory board, health task force, or school and community coalition. Police, however, are not the only key community members critical to the enforcement of policies and norms in a community. Young people, parents, and other community members play an important role in combination with police and others in the law enforcement and judicial fields.

Enforcement strategies are more likely to be effective if they:

- Are paired with collaboration and communications strategies. Community collaboration and media efforts are effective tools for increasing awareness of penalties associated with violating laws regarding alcohol and tobacco sales to minors. Media efforts are also helpful in changing or reinforcing community norms that disapprove of sales to and use by minors.

- Ensure that retailers comply with minimum purchase age laws for tobacco and alcohol. Undercover buying operations (a. k. a. “sting” or “decoy” operations) to enforce minimum purchase age laws against selling alcohol and tobacco to minors increases the likelihood that retailers will comply with such laws. Undercover community buying operations that provide positive and negative feedback to merchants are also effective in increasing retailer compliance with underage drinking laws.

- Limit driving privileges for those who violate minimum purchase age laws. Suspending the driver's license of a person under 21 years of age following a conviction for any alcohol or drug violation is an effective way of increasing compliance with minimum purchase age laws among the young.

- Limit driving privileges for those caught driving under the influence (DUI) of alcohol or drugs. Revoking a person's driver's license in the event they drive with an illegal BAC or if the driver refuses to have his/her BAC level tested has been shown to reduce the number of fatal crashes and repeat offenses among DUI offenders.

- Involve public enforcement of impaired driving laws. Visible enforcement of these laws is important because it increases the public's perception that violators will be caught and punished for drunk driving. Sobriety checkpoints are one example of this kind of public enforcement of impaired driving laws.

- Pair enforcement of laws against service to intoxicated patrons and sales to minors with server training. This combination of strategies increases the effectiveness of server training programs by improving selling and serving practices to minors and intoxicated patrons.

- Employ citizen surveillance and nuisance abatement programs. These strategies have been effective in dislocating drug dealers and reducing the number and density of retail drug markets.

EDUCATION STRATEGIES

Instructional approaches that combine social and thinking skills are one of the most effective ways of enhancing individual abilities, attitudes, and behaviors inconsistent with substance abuse and other kinds of delinquent behavior. These methods tend to be far more effective at changing behavior than educational programs that focus on imparting knowledge about substances and the adverse effects of substance abuse and on bolstering self esteem. Education programs are typically found in schools and in some after-school programs. While instructional programs have been important and necessary, and even effective at imparting knowledge, developing skills, and changing some behaviors, alone most are insufficient to produce far reaching and long-

lasting change.

Education strategies are more likely to be effective if they:

- Combine broader-based life skills instruction with resistance skills training. Certain sets of skills are particularly effective in preventing the onset of and reducing the continued use of alcohol, tobacco, and other drugs. These skills include empathy, social problem-solving or impulse control, communication, stress management or coping, media resistance, assertiveness, and belief development or normative education.

- Include an adequate dosage. At a minimum, skills-based instruction programs should include 10 to 15 sessions per year and another 10 to 15 booster sessions offered one to several years after the original intervention. Longer, more comprehensive skills-based programs that cover longer periods produce broader and more enduring changes. Further, booster sessions help students maintain skills over a longer period.

- Reach children from kindergarten through high school. Substance abuse prevention instruction strategies are more likely to be effective when they start with young children in order to prevent the later use and abuse of substances. It is especially important to reach students in the middle school or junior high years. During this time of transition, many young people begin smoking cigarettes and drinking alcohol. It is therefore important to offer programs that contain multiple years of intervention (all through the middle school or junior high years).

- Reach young people during non-school hours. You may offer social and thinking skills-based programs in a number of environments, including after-school mentoring, individual therapy, and family management training. See also "Alternative Strategies" and "Early Intervention Strategies" below.

- Use age-appropriate, interactive teaching methods. Interactive approaches that engage students in learning are more effective than didactic approaches. Interactive approaches include modeling, role playing, discussion, group feedback, reinforcement, extended practice, cooperative learning, and student-centered learning techniques.

- Foster prosocial attachment to the school and community. Students' lack of attachment to school may be related to unsatisfying academic experiences. Prevention interventions may address this issue by including components that offer academic skill-building for students.

- Include components that are led by students. Educational approaches that include peer-led components are more effective than programs that do not include these kinds of components. Peer educators usually require extensive prior instruction to prepare them to present before or engage their peers. These programs may offer one-to-one instruction or large group instruction.

- Include an educational component for parents with drug information for them and their children. Educational approaches that target parents and their children and school-based approaches that involve parents or complement student-focused curricula with parent-focused curricula can be effective in preventing adolescent substance abuse. See also "Early Intervention Strategies."

- Pair server training with enforcement of laws against service to intoxicated patrons and sales to minors. This combination of strategies increases the effectiveness of training programs by improving selling and serving practices to minors and intoxicated patrons.

COMMUNICATIONS STRATEGIES

Communications strategies influence community norms as well as increase public awareness about specific issues and problems related to substance abuse, attract community support for other program efforts, reinforce other program components, and keep the public informed about program progress. Communications strategies include: public education; social marketing campaigns that apply marketing principles to the design and implementation of communication campaigns; media advocacy approaches that lobby various media to change the way they portray substance use issues to ultimately influence policy changes; and media literacy programs that educate people to be critical of what they see and read in the media.

Communications strategies are more likely to be effective if they:

- Are combined with more intensive and interactive prevention approaches. When coupled with more potent prevention approaches (e.g., education and skills building, policy, enforcement), the media is a useful tool for reaching many people in the community.

- Present messages that appeal to the motives of young people for using substances or aggression or to perceptions of substance abuse. Messages that appeal to or correct young people's perceptions of risk are more likely to be effective at changing young people's substance-related knowledge, behaviors, and attitudes than messages that do not. For example, counteradvertising campaigns that disseminate information about the hazards of a product or the industry that promotes it may help reduce cigarette sales and tobacco consumption. Messages that correct misconceptions about prevalence of use, “Most of your friends don't smoke marijuana,” may reduce consumption, since students are more likely to engage in a particular behavior if they believe that more of their peers are doing it.

- Place messages where young people are likely to see and hear them. Pay for television and radio spots in choice airtimes, when youth are more likely to view or listen. Post placards regarding underage drinking and smoking in liquor stores or stores that sell cigarettes. Put posters in well-trafficked areas in and around schools.

- Tailor message to the audience. Ultimately, the messages you convey should be tailored to your audience. One way of determining what those messages should be is to conduct an assessment of attitudes and beliefs about substance abuse. For example, allow for the different viewing habits of younger and older adolescents, utilizing radio, television, and print media appropriately. The interests of youth also vary by gender, ethnicity, and geography. What might appeal to young people living in the city may not appeal to a young person living in a rural setting.
- Avoid the use of authority figures and admonishments, as well as the demonstration of harmful substances. Young people tune out when messages are overbearing or use scare tactics.

COLLABORATION STRATEGIES

While not directly affecting the use of tobacco, alcohol, and other drugs, collaborative efforts, community coalition building and interagency collaboration in particular, have been shown to be effective in raising awareness about the issues of substance abuse and violence and in coordinating prevention and treatment services.

Collaboration strategies are more likely to be effective if they:

- Promote or involve communities that are mobilized or ready to engage in community change activities. These communities have shown decreases in alcohol, tobacco, and other drug use and changes in perceived norms about substance use.

- Use media and community education strategies. These strategies increase public awareness, attract community support, reinforce school-based curriculum for students and parents, and keep the public informed of program progress.

- Are part of a comprehensive effort, community collaboration is more effective if it is integrated into and offered in conjunction with other effective strategies. In particular, combine this approach with media and community education strategies, since these increase public awareness, attract community support, reinforce other program efforts, and keep the public informed of the program's progress.

- Coordinate with other community efforts. Don't duplicate efforts. Look at what people in different settings—community-based organizations, health and social service sectors, schools, and so on—are already doing to prevent substance abuse, and build on those efforts. Include program components that can be integrated or coordinated with other efforts to support your messages. For example, work together to secure funding for substance abuse prevention programs, increase access to and quality of existing prevention and treatment services, make environmental changes (e.g., close crack houses, remove billboards for tobacco and alcohol), or provide alternative activities for young people.

- Reach different populations at risk. Collaborative efforts are more likely to be effective if they meet the needs of all young people as well as those at high risk. Community efforts must include representatives from different segments of the population, including different religious, ethnic, and socioeconomic groups, as well as people of all ages in order to be truly responsive.

- Meet the needs of its members. Most people want to get something specific out of their collaborative experience. Appeal to different motivations for joining. Community leaders and professionals, for example, are more likely to seek outcomes or accomplishments related to their organizational or political interests, while community or citizen activists want to spend their time in a useful way that will make their communities better places to live.

- Recruit and involve members whose positions, expertise, or skills match the purpose and plan of the coalition. For example, if direct community action is the focus of your work, then you should involve grassroots activists and community citizens.

- Possess a shared vision of purpose and direction. Community collaboration is more likely to succeed if everyone shares the same vision of what he or she would like to achieve. Getting people on the same page may require discussion about common goals, types of effective strategies, and the need for strategic planning.

- Follow a structured organizational plan. Planning is critical to school and community collaboration. Community coalitions tend to be more effective when they begin with a clear understanding of the substance-related problems they want to change. From that point, they can then progress from that assessment through the development of measurable goals and objectives, program design based on effective strategies, implementation, and evaluation and refinement of their efforts. Feedback to and from the members of the community coalition is essential at all stages.

- Avoid elaborate organizational and committee structures. Such structures can inhibit productivity and are at times counterproductive. Oftentimes complex structures can stall the motivation and productivity of a group.

- Encourage a leadership of ideas. Leadership is promoted when coalitions create opportunities for a variety of members to show leadership by demonstrating their ideas in a plan for action.

- Have specific measurable objectives and activities. These objectives and activities should be time-limited, feasible (given available resources and other constraints), and integrated so that they work together across program components and can be used to evaluate program progress and outcomes.

ALTERNATIVES STRATEGIES

Increasingly, schools and communities are working together to incorporate recreational, enrichment, and leisure activities into their approach to prevention. Drop-in recreation centers, after-school and weekend programs, dances, community service activities, tutoring, mentoring, and other events are offered in these programs as alternatives to dangerous activities such as substance abuse and violence. While many alternative approaches have not been evaluated with rigor, researchers have learned some valuable lessons about what elements increase their likelihood of success.

Alternatives strategies are more likely to be effective if they:

- Are part of a comprehensive prevention plan that includes other strategies proven to be effective. The general conclusion of researchers is that these kinds of activities alone are insufficient to affect substance abuse among youth. Enrichment and recreational activities must be paired with other strategies that have been proven effective, such as policies that reduce the availability of alcohol, tobacco, and other drugs, as well as weapons or social and personal skill-building instruction.

- Are targeted to youth at high risk that may not have adequate adult supervision or access to a variety of activities. Alternatives activities are more likely to be effective with youth at high risk for substance abuse who have few opportunities to develop the kinds of personal skills needed to avoid behavioral problems. Activities that have been successful in meeting the needs of young people at risk include the following:

* community service associated with an increased sense of well being and more positive attitudes toward people, the future, and the community

* mentoring programs related to the reduction in substance use and increases in positive attitudes toward others, the future, and the school

* recreational and cultural activities associated with decreasing substance use and delinquency by providing alternatives to substance use as well as monitoring and supervision of young people

- Are targeted to the needs and assets of the individual. If the activities you offer are not attractive to the young people with whom you work, then the young people will not participate. One way to ensure that activities interest and meet the needs of young people is to involve them, as appropriate, in creating these activities or in selecting service opportunities.

- Provide intensive approaches that include many hours of involvement with access to related services. Across Ages, for example, which matches senior citizens as mentors to sixth-graders at high risk, found that the

more highly involved the mentor, the greater the positive results. Across Ages also provided other services to youth, including skills-based instruction, family workshops on parenting skills, and other community service opportunities.

EARLY INTERVENTION STRATEGIES

Early intervention includes strategies such as screening, assessment, referral and treatment of youth at risk for substance use and related risk factors; home visitation; early education (e.g., Head Start); student assistance programs; employee assistance programs; and treatment and counseling services. Counseling interventions for youth at high risk, including student assistance programs, require more rigorous evaluation before they can be considered effective strategies. The strategies that are most effective are those designed to identify young people and their parents at risk and offer or refer them to appropriate educational or counseling programs.

Early intervention strategies are more likely to be effective if they:

- Are targeted to families considered at risk for or who are already using alcohol, tobacco, and other drugs. It is important to obtain accurate numbers of young people and families who qualify as "high risk" to justify these kinds of intervention services. Communities that do not have large numbers of young people (and families) at high risk for substance abuse should consider placing their resources elsewhere.

- Include skill-building components for both parents and children. Parents are usually trained in behavioral skills to reduce conduct problems in children; improve parent-child relations, including positive reinforcement, listening and communication skills, and problem solving; provide consistent discipline and rulemaking; and monitor children's activities during adolescence. Programs that emphasize these skills and that target families at high risk have been shown to be effective in enhancing protective factors and producing positive substance-abuse-related outcomes. Further, interventions—involving family therapy or family counseling to improve communication and foster attachment in families of delinquent youth—with substance abusing parents have been shown to improve parenting skills, reduce parents' drug use, and improve child behavior.

- Identify and expand upon the strengths of families. While helping families build the skills they need to improve parenting and strengthen bonds with their children, early interventions for families at risk should also build on the assets that families and parents already possess, rather than repeatedly focusing on what they lack.

- Offer incentives for participation. It is often difficult to recruit parents and young people into prevention programs. Provide incentives for participation that include transportation to and from training sessions and childcare or activities for children who must accompany parents to the training sessions. Schedule the program at times that are most appropriate for parents. For some parents, this may be during working hours, and for others, it may be after dinner.

- Are culturally appropriate. For example, interventions that acknowledge or address issues involved in family acculturation have produced positive effects. Some of these issues include the presence and importance of the extended family, the influence of immigration or circular migration, varying language abilities within families, the influence of religion and folk healers, the influence of voluntary and social organizations, and the stresses families experience as a result of poverty or racism.

- Address the relationship between substance abuse and other adolescent health issues. These issues include mental and emotional health, family conflict, unwanted or unintended pregnancy, sexually transmitted diseases, school failure, and delinquency.

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APPENDIX D

EXAMPLES OF SCIENCE-BASED PREVENTION MODELS

The following program descriptions are examples of the programs considered science-based by CSAP. Note that this does not represent the universe of science-based programs identified by all federal agencies and their contractors, simply the latest programs for which CSAP has good evidence.

CSAP feels that these projects can be replicated in communities and offer the techniques used to address the problem and how they decrease substance abuse among youth.

In addition, an annotated bibliography of selected science-based prevention documents is provided at the end of this appendix.

ACROSS AGES

What is the Across Ages Program?

The Across Ages program is a research-based mentoring initiative in Philadelphia, Pennsylvania, that successfully improved adolescents' social competence and enhanced their ability to resist alcohol, tobacco, and drug use. The required highly effective feature of Across Ages is the pairing of middle school youth with older adult mentors, who provide the children with positive, nurturing role models.

Who Can Benefit?

The target population of Across Ages is middle school students ages 10 to 13. The original participants were African-American, Asian, Hispanic, and White children, many of whom lived in poverty, experienced repeated school failure, and had family members involved in drug use.

Suitable Settings

Across Ages can be implemented by a school or school district or by other organizational serving youth and their families, provided the local community has an adequate number of concerned residents age 55 and older. The initial program paired sixth-graders in three North Philadelphia middle schools with elderly residents of the city.

Essential Components

Successful replication of the Across Ages model involves:

- Elders mentoring youth;
- Youth performing community service;
- Youth learning problem-solving and resistance skills; and
- Parental involvement.

How the Program Works

Implementing the Across Ages model involves the following activities:

- Intergenerational mentoring on a one-on-one basis.
- Engaging youth in community service activities.
- Training classroom teachers to administer the life skills curriculum.
- Providing weekend and evening activities to engage families, mentors, and youth.

What You Can Achieve

• Dramatically improve school attendance and increase academic competence.
• Increase knowledge about and negative attitudes toward alcohol and tobacco use.
• Boost adolescents' self-esteem, problem-solving skills, and positive social support networks.
• Generate supportive parent involvement in class room and project activities.
• Foster collaboration among the youth service, aging, and educational systems.

Contact Person:
Andrea S. Taylor, Ph.D.
Temple University, Center for Intergenerational Learning
1601 N. Broad Street, USB 206
Philadelphia, Pennsylvania 19122
(215) 204-6708
Fax: (215) 204-6733

CHILD DEVELOPMENT PROJECT (CDP)

What is the Child Development Project?

The Child Development Project (CDP) is a research-based school-improvement initiative designed by the Development Studies Center of Oakland, California, which, by transforming elementary schools into "caring communities of learners," significantly reduced children's use of alcohol and illicit drugs while dramatically increasing the children's resilience to substance use. CDP scientifically demonstrates that nurturing a student's intrinsic desire to learn, cultivating supportive relationships, and promoting the child's sense of common purpose and commitment to pro-social values are effective protection against the risk of substance use.

Who Can Benefit?

CDP is a comprehensive, multifaceted school-change program that involves elementary school students of all grade levels, the students' families, teachers, and school administrators. The original student populations varied widely: anywhere from 2 percent to 95 percent of children were receiving free or reduced-price lunch, and 26 percent to 100 percent were members of minority groups. Achievement test scores ranged from the 24th to the 67th percentile.

Suitable Settings

CDP can be implemented in virtually any rural, suburban, or urban elementary school. The elementary schools that participated in the CSAP-funded demonstration projects were located in Jefferson County, Ky; Dade County, Fla.; and White Plains, N.Y.

Essential Components

Successful replication of the CDP model involves:

• Building warm, stable, supportive relationships among all members of the school community;
• Attending to the intellectual, social, and ethical dimensions of learning in an integrated manner;
• Teaching in ways that promote students' understanding and make learning meaningful for them; and

• Honoring and fostering students' intrinsic motivation to learn.

How the Program Works

Implementing the complete CDP model involves two phases.

Phase One focuses on building a strong sense of community in the school; that is, students' sense of belonging to, contributing to, and having a voice in a caring school environment. Activities that promote a sense of community include those that:

• Foster cross-age/cross-grade relationships.
• Promote parental involvement in their child's learning.
• Build connections between the school and the families it serves.

Phase Two promotes change in the classroom climate, curriculum, and teaching style. This phase of the program introduces:

• A values-rich, literature-based reading program.
• Multiple cooperative learning activities that can be used across the curriculum.
• A "teaching" approach to classroom management that helps students take responsibility for establishing classroom norms and for managing their own behavior.

What You Can Achieve

• Increase students' liking for school and enjoyment of class.
• Boost children's motivation to learn.
• Encourage greater concern for others and more frequent altruistic behavior.
• Improve children's ability to resolve conflicts.
• Strengthen children's sense of community and commitment to democratic values.
• Increase resistance to substance use.

Contact Person:
Denise Wood, Developmental Studies Center Information Coordinator
2000 Embarcadero, Suite 305
Oakland, California 94606-5300
(800) 666-7270, ext. 239
E-mail: denise_wood@devstu.org

SMART LEADERS

What is the SMART Leaders Program?

SMART Leaders is a two-year, sequential booster program for youth who have completed Stay Smart, a component of the Boys & Girls Clubs of America's SMART Moves program. SMART Leaders was developed by Tena L. St. Pierre, Ph.D. and D. Lynne Kaltreider, M.Ed. at The Pennsylvania State University's Institute for
Policy Research and Evaluation. Evaluation results show the effectiveness of a multi-year approach in promoting refusal skills and creating drug-free peer leaders.

Who Can Benefit

SMART Leaders is designed for 14- to 17-year-olds at risk who have completed Stay SMART (ages 13 to 15). Youth also may participate in Start SMART (ages 10-12), another component of SMART Moves, before taking part in Stay SMART. Target populations in the demonstration projects were African-American, Hispanic, and White.

Suitable Settings

The SMART Leaders program can be implemented in community-based youth organizations, recreation centers, and schools. The demonstration projects were implemented in Boys & Girls Clubs, a number of which are in or adjacent to public housing projects.

Essential Components

Successful replication of the SMART Leaders model involves:

- Structured experiential and discussion sessions for youth; and
- Youth activities/outings.

How the Program Works

The SMART Leaders component consists of three parts:

- An educational curriculum focusing on self-esteem; coping with stress; and resisting pressures to use drugs and to engage in sexual activity.
- Peer leadership activities.
- Monthly youth activities.

What You Can Achieve

- Strengthen adolescents' resistance to alcohol, tobacco, and illicit drug use.
- Increase adolescents' knowledge of and negative attitudes toward alcohol, tobacco, & illicit drug use.

Contact Person:

The contact person is Mylo Carbia-Puig. Please see the Family Advocacy Network project description for her address.

FAMILY ADVOCACY NETWORK (FAN CLUB)

What is the FAN Club Program?

The FAN Club program directly involves parents of youth participating in the Boy & Girls Clubs of America's SMART Moves program, including the SMART Leaders booster program. The FAN Club strengthens families and promotes family bonding, thereby increasing the resistance of youth to drug use. The FAN Club was developed by Tena L. St. Pierre, Ph.D. and D. Lynne Kaltreider, M.Ed. at The Pennsylvania State University's Institute for Policy Research and Evaluation.

Who Can Benefit

The FAN Club is designed for parents of participants in B&GCA's SMART Moves program. Target populations in the demonstration project were African-American, Hispanic, and White.

Suitable Settings

The FAN Club program can be implemented in community-based youth organizations, recreation centers, and schools. The demonstration project was implemented in Boys & Girls Clubs, a number of which are in or adjacent to public housing projects.

Essential Components

Successful replication of the FAN Club model involves:

- Basic support services for parents and families;
- Social, educational, and leadership activities for parents.

How the Program Works

The FAN Club model must be implemented in combination with SMART Moves. The FAN Club component involves four categories of activities:

- Individual basic support to help families deal with stress and to encourage family activities.
- Regularly scheduled group social activities.
- Educational and enrichment activities.
- Parental leadership activities.

What You Can Achieve

- Strengthen adolescents' resistance to alcohol, tobacco, and illicit drug use.
- Increase adolescents' knowledge of and negative attitudes toward alcohol, tobacco, and illicit drugs.

Contact Person:

Mylo Carbia-Puig
Boys & Girls Clubs of America
1230 W. Peachtree St., NW
Atlanta, GA 30309-3447
(404) 487-5766
Fax: (404) 487-5789

CREATING LASTING CONNECTIONS (CLC)

What is Creating Lasting Connections?

The CLC program is a 5-year demonstration project in the City of Louisville, Kentucky, and six surrounding counties, which scientifically demonstrates that youth and families in high-risk environments can be assisted to

become strong, healthy, and supportive families, which in turn significantly increases the children's resilience to substance use and dramatically reduces their use of alcohol and illicit drugs. CLC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication.

Who Can Benefit

CLC is highly effective with youth aged 11 to 15 in high-risk environments and their families (including siblings aged 9 to 17). The original participants were primarily African-American, White, and mixed ethnic populations in rural, suburban, and inner-city settings.

Suitable Settings

CLC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings, which have significant contact with parents and youth, have existing social outreach programs, and are linked with other human service providers.

Essential Components

- Community mobilization;
- Identification and recruitment of families at risk;
- Family and youth training;
- Referral to community services; and
- Team building.

How the Program Works

Implementing the CLC model involves the following:

- Identification, recruitment, assessment, and selection of the community system(s) that will serve as the focal point of the program.
- Creation, orientation, and training of a cadre of volunteers from the community to act as advocates for youth in high-risk environments and their families and to recruit and help retain those families in the program.
- Participation of parents and youth in five highly interactive training modules.
- Early intervention services and follow-up case management services to connect families to community resources and appropriate alternative activities.

What You Can Achieve

- Increase community involvement in promoting the healthy development of youth and fostering strong, nurturing families.
- Improve family communication and family bonding.
- Increase families' use of community services, including treatment and rehabilitation.
- Improve teens' communication and refusal skills.
- Delay the onset and reduce the frequency of alcohol and drug use.

Contact Person:

Ted N. Strader, M.S.
Council on Prevention and Education: Substances, Inc.
845 Barret Avenue
Louisville, Kentucky 40204
(502) 583-6820
Fax: (502) 583-6832

DARE TO BE YOU

What is the DARE To Be You Program?

The DARE To Be You Program is a 5-year demonstration project that, by dramatically improving parent and child resiliency factors, particularly in the areas of communication, problem-solving, self-esteem, and family skills, significantly lowers the risk of future substance abuse and other high-risk activities. This multilevel prevention program is an adaptation of the DARE To Be You community and school training programs.

Who Can Benefit

DARE To Be You is designed as a primary prevention program for children ages 2 to 5 and their families.

Suitable Settings

DARE To Be You can be implemented in any urban, suburban, or rural community. The initiative was implemented in community centers, day care facilities, and Head Start facilities across Colorado.

Essential Components

Successful replication of the DARE To Be You model involves:

- Education and social activities for parents, children, and families; and
- Training and support for day care, Head Start, and other child care providers and community members who will provide ongoing support to the target children and their families.

How the Program Works

The DARE To Be You model consists of:

- A Family component, which offers parent, youth, and family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills.
- A School component, which trains and supports childcare providers.
- A Community component, which provides training in the DARE To Be You strategies to community members who interact with the target families.

What You Can Achieve

• Improve parents' sense of competence.
• Provide parents with knowledge and understanding of appropriate child management strategies.
• Improve parents' and children's relationships with their families and peers.
• Boost children's developmental levels.

Contact Person:

Jan Miller-Heyl, M.S.
DARE To Be You, Colorado State University Coop. Ext.
215 N. Linden, Suite E
Cortez, Colorado 81321
(970) 565-3606
Fax: (970) 565-4641

RESIDENTIAL STUDENT ASSISTANCE PROGRAM (RSAP)

What is RSAP?

The Residential Student Assistance Program (RSAP) is a 5-year demonstration project in Westchester County, New York, which has dramatically reduced substance use among institutionalized adolescents at risk. RSAP is adapted from the county's successful Student Assistance Programs, similar to Employee Assistance Programs used by industry to identify and aid employees whose jobs and lives have been harmed by substance use.

Who Can Benefit

RSAP is uniquely designed to address the needs of seriously troubled 14- to 17-year-olds. The original participants were primarily African-American and Hispanic.

Suitable Settings

RSAP can be implemented in virtually any residential facility for adolescents. The facilities involved in this project included a locked county correctional facility; a non-secure residential facility for juvenile offenders sentenced by the court; a residential treatment center for adolescents with severe psychiatric problems; and three foster care facilities for abused, neglected, orphaned, or troubled adolescents placed by social services.

Essential Components

Successful replication of the RSAP model involves:

• Prevention education discussion groups;
• Individual and group counseling;
• Training for and consultation with the residential facility staff; and
• Referrals for treatment and 12-step meetings.

How the Program Works

A highly trained, professional Student Assistance Counselor provides culturally sensitive substance abuse prevention and intervention services, including:

- Substance abuse assessment of all new residents entering the facility.
- The Prevention Education Series curriculum for youth to help identify adolescent substance users and children of substance abusers, encourage self- and peer-referrals, and provide primary prevention activities for non-users.
- Individual and group educational and motivational counseling for residents whose parents are substance abusers.
- Group counseling to help residents identify and resist social and situational pressures.
- Outreach activities to engage residents who are reluctant to discuss alcohol and drug problems.

What You Can Achieve

- Decrease adolescents' use of alcohol, tobacco, and marijuana.
- Enhance the resiliency of adolescents whose parents are substance abusers.
- Boost the ability of residential facility staff to implement substance abuse prevention strategies.

Contact Person:

Ellen R. Morehouse, ACSW, CASAC
Student Assistance Services
300 Farm Road
Ardsley, New York 10502
(914) 674-0400
Fax: (914) 674-0972

SCIENCE-BASED PREVENTION: AN ANNOTATED BIBLIOGRAPHY

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The following bibliography of selected science-based prevention documents was compiled to give practitioners the opportunity to access current information related to effective substance abuse prevention programs, strategies and principles.

Publications available through NCADI can be ordered using the publication number provided by calling 1-800-729-6686, or by printing and faxing a publications order form from the NCADI catalog, available at http://www.health.org/pubs/catalog/index.htm

Brounstein, P. J., Zweig, J. M., & Gardner, S. E. (Dec. 7, 1998). Science-based practices in substance abuse prevention: A guide. Working draft. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Division of Knowledge Development and Evaluation.

> CSAP researchers present a conceptual model for substance abuse prevention and share a set of criteria used to identify science-based practices. The second half of the guide details scientifically defensible programs and principles and discusses how these findings can be used successfully. Full text is available on the CAPT website at: www.edc.org/capt/csap/papers/gardner_cover.html

Center for Substance Abuse Prevention. (1996). CSAP technical report 13: A review of alternative activities and alternatives programs in youth-oriented prevention. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This document reviews research and case examples of alternative activities in substance abuse prevention. Program types including community service and mentoring and their relative effectiveness are discussed. (NCADI Publication Number: SMA96-3117)

Center for Substance Abuse Prevention. (1997). Effective community mobilization: lessons from experience. A CSAP implementation guide. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This publication presents actual examples of community mobilization along with a series of key characteristics of successful efforts. The intended audience is state substance abuse agencies, community leaders, and citizens who participate in community mobilization efforts. (NCADI Publication Number: PHD739)

Center for Substance Abuse Prevention. (1998). Preventing substance abuse among children and adolescents: Family-centered approaches. P.L. Grover, (Ed). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This series summarizes state-of-the-art approaches and interventions designed to strengthen the role of families in substance abuse prevention. The guides focus on research and practice evidence for a select number of approaches to preventing family-related problems. (This series includes a Parent and Community Guide, a Guideline for Prevention Practitioners, and a Reference Guide. NCADI Publication Numbers: PHD758, PHD759, PHD760)

Center for Substance Abuse Prevention. (1997). Reducing tobacco use among youth: Community-based approaches. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This series identifies the relative effectiveness of various tobacco prevention approaches, including economic interventions, counter-advertising, retailer-directed interventions, multi-component approaches, tobacco-free policies, and advertising and promotion restrictions. (This series includes a Community Guide, a Guideline for Prevention Practitioners, and a Reference Guide. NCADI Publication Numbers: PHD744, PHD745, PHD746) Full text of A Guideline for Prevention Practitioners is available online at: http://www.health.org/pepspractitioners/index.htm

Center for Substance Abuse Prevention. (1997). Selected findings in prevention: A decade of results from the Center for Substance Abuse Prevention. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This document shares findings in substance abuse prevention related to the efficacy of specific prevention activities, prevention implementation, cost and financing of prevention, and suggestions for future investigation. (NCADI Publication Number: PHD747)

Center for Substance Abuse Prevention. (1999). Understanding substance abuse prevention. Toward the 21st century: A primer on effective programs monograph. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

This monograph assesses the effectiveness of programs in CSAP's High-Risk Youth Demonstration Grants Program. Program descriptions and other relevant information is provided for eight model programs. (NCADI Publication Number: BKD322) Full text is available online at: http://www.whitehousedrugpolicy.gov/prevent/high_risk/toc.htm

National Institute on Drug Abuse. (1997). Drug abuse prevention for at-risk groups. Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

The history and key features of selective prevention programs are shared. The Strengthening Families Program — a family-focused program aimed at children of parents who abuse substances — is discussed in detail. (NCADI Publication Number: BKD201)

National Institute on Drug Abuse. (1997). Drug abuse prevention for at-risk individuals. Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

The history and key features of indicated prevention programs are shared. The Reconnecting Youth program — a school-based intervention targeting high school students at risk for substance abuse and related problems — is discussed in detail. (NCADI Publication Number: BKD202)

National Institute on Drug Abuse. (1997). Drug abuse prevention for the general population. Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

The history and key features of universal prevention programs are shared. The Project STAR program — a community-wide skills-building effort to counteract psychosocial influences that can lead to drug abuse — is discussed in detail. (NCADI Publication Number: BKD200)

National Institute on Drug Abuse. (1997). Drug abuse prevention: What works. Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

This guide provides an overview of prevention theory with a focus on risk and protective factors. Key features of universal, selective, and indicated approaches are discussed. (Document included as part of NCADI Publication Number: PREVPK)

National Institute on Drug Abuse. (1997). Preventing drug use among children and adolescents: A research-based guide. Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

Preventing Drug Use provides research-based information to help practitioners develop effective drug abuse prevention programs. An overview of research on risk and protective factors and basic principles derived from effective prevention programs are included. Descriptions of several research-based prevention programs are also included. (NCADI Publication Number: PHD734) Full text is available online at: http://www.nida.nih.gov/prevention/prevopen.html

Sherman, L.W., Gottfredson, D., MacKenzie, D., Eck, J., Reuter, P., and Bushway, S., (Eds.) (1997). Preventing crime: What works, what doesn't, what's promising. A report to the United States Congress. Prepared for the National Institute of Justice by the Department of Criminology and Criminal Justice, University of Maryland.

Based on a review of more than 500 prevention program evaluations that met minimum scientific standards, this report establishes a provisional list of what works, what doesn't, and what is promising. Full text is available online at: http://www.ncjrs.org/works/index.html

APPENDIX E

PREVENTION NEEDS ASSESSMENT

Introduction

Statewide student surveys conducted in Connecticut have shown that alcohol, tobacco, and other drug use among Connecticut youth has increased over the past decade (Hartwell et al., 1996). Furthermore, the prevalence of substance use among Connecticut youth is greater than the prevalence in both the Northeast region of the country and nationwide. While the patterns of substance use and the factors contributing to use may vary, adolescent substance use and its consequences are a subject of concern in all Connecticut communities.

From April to October 1997 a representative sample of 15,733 students in 5th-12th grades in twenty-seven randomly selected school districts completed the Connecticut Substance Abuse Prevention Student Survey. Researchers from the University of Connecticut Health Center administered the survey. This survey was part of a statewide student substance abuse prevention needs assessment conducted for the Connecticut Department of Mental Health and Addiction Services (DMHAS) under contract with the Center for Substance Abuse Prevention (CSAP).

The survey objectives were: 1) to estimate the prevalence of alcohol, tobacco, and other drug use among students, and 2) to measure the risk and protective factors for substance use in the student population. Risk factors are situations or characteristics that may increase the likelihood of a youth using alcohol, tobacco or other drugs, such as the availability of substances, having friends who use, and tolerant attitudes toward drug use. Protective factors are situations or characteristics that decrease the likelihood of substance use among youth. Protective factors for youth substance use include a close parent-child relationship, commitment to school, perceived harm of substance use, and community norms that discourage substance abuse among youth. These risk and protective factors occur within several domains:

- Individual (e.g., biological and psychological dispositions, attitudes, values, knowledge, skills, and problem behaviors)
- Peer (e.g., norms and activities)
- Family (e.g., function, management and bonding)
- School (e.g., commitment, performance, climate, and policy)
- Community (e.g., bonding, norms, awareness, mobilization and resources)

Prevention programs that seek to reduce or prevent the initiation of substance use employ strategies that target specific risk factors or enhance protective factors. These risk and protective factors are also important for understanding and preventing other adolescent problem behaviors, such as school dropout, truancy, delinquency, violence, and teen pregnancy.

Selected findings

1. **The average age that Connecticut students begin using substances is decreasing**

   - The average age that an 8th grade student begins using cigarettes is 11 years old
   - In 1989 the average 8th grader tried alcohol for the first time when they were 12½ years old, compared to 11 years old in 1995
   - In 1989 the average 8th grader tried marijuana for the first time when they were 13½ years old, compared to 12 years old in 1995

2. **Alcohol is the most widely used substance among students across all age groups**

   - One in five 5th graders reported using alcohol in their lifetime
   - By the time students reached the 12th grade, 85% reported that they had used alcohol, which is similar to the proportion of Connecticut adults who have used alcohol
   - Recent alcohol use decreased among 7th-8th graders from 1995 (35%) to 1997 (26%), but still remained the most widely used substance among this age group

3. **Cigarettes are widely used by Connecticut students**

   - One in ten 5th graders and two out of three 12th graders reported they had tried cigarettes
   - From 1995 to 1997 recent cigarette use among 9th-10th graders increased from 26% to 31%, and use among 11th-12th graders increased from 34% to 37%

4. **Inhalant use is increasing**

   - 16% of students have tried inhalants by the time they leave the 8th grade
   - More students reported recent use of inhalants in 1997 than in 1995

5. **Marijuana and other illicit drug use is increasing**

   - More than half of all students will have tried marijuana by the time they leave high school
   - One out of five students will have tried cocaine, crack, heroin, PCP, or hallucinogens by the time they leave high school
   - From 1995 to 1997, marijuana and other illicit drug use increased for high school students

6. **The gap in substance use rates between girls and boys is closing**

   - Increases in alcohol, cigarette and marijuana use among high school students from 1995 to 1997 were more likely to occur among girls than boys

- Boys are still more likely than girls to use alcohol or marijuana, but the gap is decreasing
- Boys across all age groups were more likely than girls to report recent use of illicit drugs
- High school girls were more likely to report recent use of cigarettes compared to high school boys

7. Whites, blacks and Hispanics report varying levels of substance use

- Black 5th-6th grade students reported higher rates of recent cigarette use than whites or Hispanics
- Among 7th-8th grade students, Hispanics reported the highest rates of alcohol, cigarette, and marijuana use
- Black 7th-8th graders reported the lowest rates of recent alcohol and cigarette use
- White 7th-8th grade students reported less recent use of marijuana and other illicit drug use than blacks or Hispanics

APPENDIX F

INSTITUTE OF MEDICINE'S (IOM) CLASSIFICATION OF PREVENTION INTERVENTION

Institute of Medicine Classification of Prevention Interventions

Universal

Universal preventive interventions are designed to reach the entire population, without regard to individual risk factors, and they generally are designed to reach a very large audience. Participants are not recruited to participate in the program and the degree of individual substance abuse risk of the program participants is not assessed. The program is provided to everyone in the population (national, local community, school, and neighborhood) regardless of whether they are at risk for substance abuse. Examples of universal preventive interventions for substance abuse include substance abuse education for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and social policy changes, for example reducing availability by reducing the number of liquor outlets in a municipality.

Selective

Selective preventive interventions target subgroups of the general population that are determined to be at risk for substance abuse. Recipients of selective prevention interventions are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's profile, but the degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed. Vulnerability is presumed on the basis of their membership in the at-risk group. Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives. Selective programs generally run for a longer period of time and require more time and effort from participants than universal programs. Examples of selective preventive intervention for substance abuse include special clubs and groups for children of alcoholics, rites of passage programs for at-risk males, and skill training programs that target young children of substance-abusing parents.

Indicated

Indicated preventive interventions identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs. The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological problems such as depression and suicidal behavior that increase their chances of developing a drug abuse problem. Indicated prevention approaches require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at risk group as in the selected approach. Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at greater frequency of contact and require greater effort on the part of the participants than do selective or universal programs. Programs require highly skilled staff who have clinical training and counseling skills or other clinical intervention skills. In the field of substance abuse, an indicated preventive intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

The above was taken from "Reducing Risks for Mental Health Disorders: Frontiers for Preventive Intervention Research." National Institute of Medicine.

APPENDIX G

CONNECTICUT'S INTERMEDIATE OUTCOMES: BASELINE RISK & PROTECTIVE FACTORS CHART

Connecticut Intermediate Outcomes: Baseline Risk and Protective Factors

Introduction

The vision for Connecticut is the quantifiable reduction of substance use through a statewide substance abuse prevention system that allows its citizens to live healthy, productive and rewarding lives. One objective of the State Incentive Project is to reduce substance use among 12-17 year old youth through the identification of intermediate outcomes.

Intermediate outcomes are state of the art, short-term indicators to measure progress toward a long-term goal. These outcomes are based on research about what factors increase or decrease the likelihood of substance use and are referred to as risk or protective factors. Risk factors are situations or characteristics that may increase the likelihood of a youth using alcohol, tobacco or other drugs and protective factors are situations or characteristics that decrease the likelihood of substance use among youth. These factors are classified into four different areas of influence that shape the development and decisions of adolescents to use substances. These areas, or domains, are the individual/peer, family, school, and community.

The following list of intermediate outcomes have been developed by the Connecticut Alcohol and Drug Policy Council and adopted by the Connecticut State Incentive Project. Applicants are encouraged to focus on intermediate outcomes when considering the prevention efforts identified for their respective community. Because these outcomes are associated with substance use, prevention efforts should focus on addressing these outcomes as a means of reducing substance use.

State Incentive Grant
Connecticut Intermediate Outcomes: Baseline Risk and Protective Factors

Constructs	Evidence	Indicators	Desired Outcomes	Instruments/ Measures
Community Domain				
Community Attitudes and Norms	Increase in alcohol tax leads to decrease in consumption and cirrhosis mortality; higher drinking age is associated with fewer teen traffic fatalities and DWI citations; norms, attitudes or standards which oppose the use of ATOD by teenagers are associated with less use.	Youth perceptions of the extent to which adults in the community condone ATOD use	♦ **Increase community attitudes unfavorable to ATOD use** ♦ **Increase sanctions against youth ATOD use**	♦ **Youth Survey** ♦ Cost of tobacco or alcohol tax ♦ Number of compliance checks ♦ Alcohol related traffic stops/1,000
Number of Adults Known to Use ATOD	Prevalence of adult ATOD use/abuse precedes and is a predictor of teen ATOD use/abuse.	Youth reports of adults they know who use ATOD	♦ **Decrease prevalence of adult ATOD use/abuse**	♦ **Youth self-report** ♦ Alcohol/Tobacco sales/1,000 ♦ Adult ATOD related deaths/1,000
Alcohol & Tobacco Sales to Youth	Increased alcohol availability and accessibility leads to increases in drinking prevalence, amount of alcohol consumed, and heavy use of alcohol.	Availability & accessibility of alcohol & tobacco to youth & percent of retail outlets selling to youth	♦ **Decrease perceived availability of ATOD** ♦ **Reduce youth ATOD access**	♦ **Youth self-report** ♦ Counts & Percentages of Retail Outlets ♦ Alcohol/Tobacco Sales/licenses/1,000 ♦ Juvenile liquor law arrest rate
Family Domain				
Family Management	Lack of or inconsistent parental discipline predicts initiation of drug use.	Lack of or inconsistent parental discipline	♦ **Increase family management skills** ♦ **Parental enforcement of no use policy**	♦ **Youth self-report** ♦ Child abuse & neglect referrals/1,000 ♦ DCF placements
Parental Attachment	Lack of parent-child closeness relates to drug initiation; bonding inhibits delinquency and drug use.	Extent to which youth feel connected to their parents	♦ **Increase parental-child attachment & social bonding** ♦ Increase parental involvement	♦ **Youth self-report** ♦ Children living apart from parents ♦ Children living in foster care
Perceived Parental Attitudes Toward Youth ATOD Use	Parental expectations & communication of non-use by their children is a significant protective factor.	Youth perceptions of the extent to which their parents feel it is wrong for youth to use ATOD	♦ **Increase anti-ATOD parental attitudes**	♦ **Youth self-report** ♦ Adult liquor law arrest rate ♦ Adult DUI arrest rate

Constructs	Evidence	Indicators	Desired Outcomes	Instruments/ Measures
Family History of ATOD Use	Parental and sibling alcoholism and drug use increases risk of alcoholism, drug use initiation, and drug use in children.	Youth reports of members of their family who use or have used ATOD	♦ **Increase access to ATOD screening and treatment** ♦ **Increase positive parental modeling of non-use**	♦ **Youth self-report** ♦ Adult AOD Treatment Admissions/1,000
School Domain				
Commitment to Education	Drug use is significantly lower among students expecting to attend college.	Extent to which youth feel connected and committed to school	♦ Increase school commitment	♦ Youth self-report ♦ Hours spent on homework or school activities
School ATOD Policies		Youth perceptions of the extent to which school ATOD policies are enforced	♦ **Increase school enforcement of ATOD policies** ♦ School policies	♦ **Youth self-report** ♦ Presence/Absence of drug & alcohol policy
School Attendance	Truancy is associated with drug involvement and delinquency.	Frequency of school absenteeism	♦ Increase/improve school attendance ♦ Increase/improve school truancy policies & interventions	♦ Youth self-report ♦ Truancy Rate ♦ Drop Out Rate
Academic Success	Good school performance reduces the likelihood of frequent drug use; failure in school predicts adolescent drug abuse, frequency and levels of use of illicit drugs.	Level of youth academic achievement & school performance	♦ Increase academic achievement	♦ Youth self-report ♦ Grades ♦ Mastery Scores
Constructs	**Evidence**	**Indicators**	**Desired Outcomes**	**Instruments/ Measures**
Individual and Peer Domain				
Friends Who Use ATOD	Having friends who use/abuse ATOD precedes and is a strong predictor of teen use and abuse.	Number of close friends of youth who use ATOD regularly	♦ **Decrease youth use** ♦ Decrease youth approval of ATOD use	♦ **Youth self-report** ♦ Juvenile ATOD related arrests/1,000
Youth Attitudes Toward ATOD Use	Youth expectations & communication of non-use is a significant protective factor.	Youth perceptions of the extent to which it is wrong to engage in ATOD use	♦ **Increase youth involvement in anti-ATOD efforts** ♦ Increase youth communication of disapproval of use	♦ **Youth self-report**
Perceived Risk or Harm	Increased perceptions of harm precede and are associated with decreases in ATOD use.	Youth perceptions of the extent to which ATOD use is harmful to their health	♦ **Increase perceived harm of ATOD**	♦ **Youth self-report**

Constructs	Evidence	Indicators	Desired Outcomes	Instruments/ Measures
Perceived Availability of ATOD	Youth expectations & communication of ATOD availability, and increased ATOD availability, leads to increases in ATOD prevalence, amounts consumed, and usage.	Youth perceptions of the ease or difficulty of obtaining ATOD for their own use	♦ Decrease perceived availability of ATOD in youth	♦ Youth self-report
Antisocial Behavior	Early aggressive or antisocial behavior persisting into early adolescence predicts later adolescent aggressiveness, drug abuse and/or alcohol problems.	Youth self report of the extent to which they engage in a variety of other anti-social behaviors	♦ Prevent or reduce youth anti-social behavior ♦ Decrease tolerance of anti-social behavior ♦ Prevent or reduce youth involvement in Juvenile Justice System	♦ Youth self-report ♦ Juvenile Arrests/1,000 ♦ Teen pregnancy rate ♦ Teen violent death rate
Involvement in Pro-social Activities	Children involved in pro-social activities in school and in the community are less likely to use drugs.	Youth self report of involvement in positive social activities in school & in their community	♦ Increase pro-social involvement and positive peer interactions	♦ Youth self-report ♦ Hours spent volunteering ♦ Hours spent religious groups ♦ Hours spent sports/clubs ♦ Hours spent school activities ♦ Hours spent tutoring ♦ Hours spent mentoring ♦ Hours spent prevention programs

APPENDIX H

SCIENCE-BASED LEVELS OF RIGOR

CSAP'S LEVELS OF RIGOR

5 Types of Scientific Review Processes

Selection of Science-Based Programs

Communities funded by the Governor's Prevention Initiative for Youth will be required to use the guide below to select and implement prevention plans. Prevention plans must meet one of the types or degrees of **"rigor"** in science based prevention efforts. Rigor means the program is believable, useful, and can be generally applied to other populations.

The federal funding agency, the Center for Substance Abuse Prevention, allows for a minimum of 60% of funds to be used to fund model programs included in Types 3, 4 and 5. Type 1 is considered a review process, but the result does not meet the requirements of scientific rigor. Type 2 represents a more rigorous type of review, but still does not reflect scientifically defensible results. Types 3, 4, and 5 represent review processes from which results can be deemed scientifically defensible.

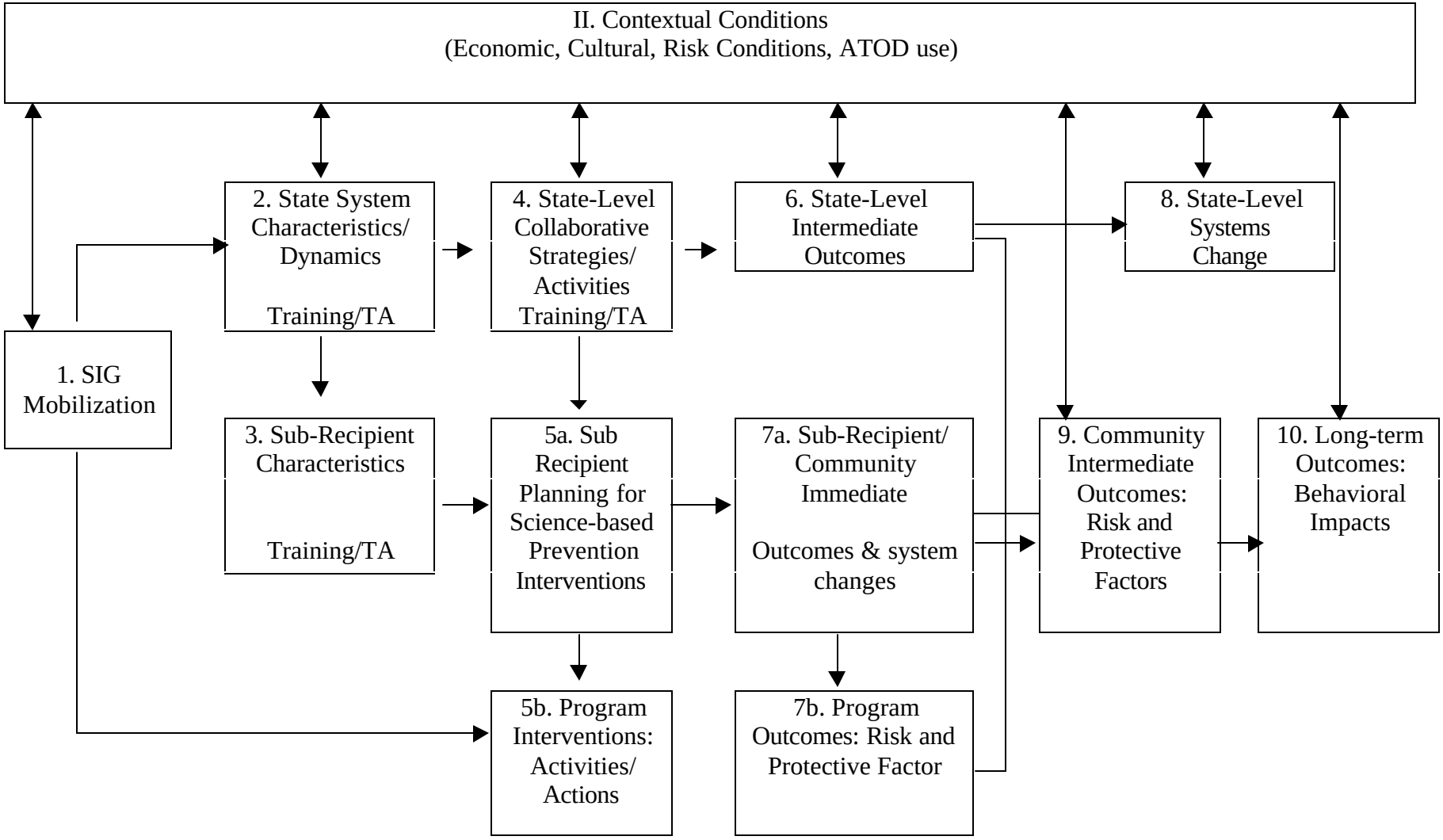
Figure 1

Type	Model Science-Based Programs	Criteria for Science Based Programs
Type 1	The prevention programs or principle has been identified or recognized publicly, received awards, honors, mentions.	♦ A panel of persons qualified in both the fields of substance abuse prevention and research methods must have reviewed and critiqued the proposed program or model. ♦ The panel determines the quality of the program's implementation plan and and overall quality of research plan and analysis.
Type 2	The prevention model or principle has appeared in professional publication or journal without being reviewed, critiqued, and judged (refereed) by professional peers. This type separates programs and principles found in professional publications from those found in professional journals.	♦ Professional publications: Prevention program information that appears only in such professional publications, should be reviewed as having merit, but should not be viewed as scientific support for a particular program model or principle. ♦ Professional journals: Information that appears in non-refereed professional journals generally offers better information about the credibility of the information. It is important to distinguish between refereed (peer/expert review) journals and journals which do not have such level of review.
Type 3	The prevention program's source documents have undergone thorough scrutiny in an expert/peer review process for the quality of implementation and evaluation methods or the paper has appeared in a peer reviewed refereed journal.	♦ Report of study methods and findings appear in expert/peer reviewed journal. ♦ Complete source documents have been scrutinized. All dosage information and data collection processes are made plain and all analysis is laid out for review. ♦ The program is rated as producing credible information regarding principles of prevention and judged to have potential as an effective model for prevention.
Type 4	The model program or principles has undergone either an expert/peer consensus process or quantitative meta-analysis in the form of a qualitative or meta-analysis.	♦ Multiple studies are reviewed and coded, generally first for the quality of methodological rigor and then for findings. ♦ A broad array of program intervention and evaluation strategies has built confidence that the principles are real and solidly defensible and related causally to the observed effects.
Type 5	Replications of model programs or principles have appeared in several refereed professional journals.	♦ The best evidence of the effectiveness of a program model's strong scientific basis is that it can be replicated across venues and populations, demonstrating credibility, utility and generalizability. ♦ Programs can be either replicated exactly or principles derived can be replicated conceptually. ♦ Evidence of replication is found in refereed journal articles or meta-analytic efforts. ♦ Successful replication of an effective program model or principle provides support for the principles upon which the program is based and for the intervention strategy as a whole.

APPENDIX I

EVALUATION FRAMEWORK

EVALUATION FRAMEWORK



APPENDIX J

TECHNICAL ASSISTANCE RESOURCES

TECHNICAL ASSISTANCE RESOURCES

The entities below can assist in providing the services indicated:

a) INFORMATION & MATERIALS *(books, pamphlets, articles, videos, etc…)*	
RESOURCE	**AREAS COVERED**
CT Clearinghouse 334 Farmington Avenue Plainville, CT 06062 Telephone #: (800) 232-4424 Fax #: (860) 793-9813 Web address: www.ctclearinghouse.org Contact: John Daviau, Program Coordinator Email address: John@ctclearinghouse.org	Statewide
b) TRAINING & TECHNICAL ASSISTANCE *(professional development, technical assistance to schools, business, colleges…)*	
The CENTER 111 Founders Plaza 12th Floor East Hartford, CT 06108 Telephone #: (860) 610-4646 Fax #: (860) 610-4647 Web address: www.etpinc.org Contact: Fred Smith, Director of Prevention Services Email address: Fsmith@etp.org	Statewide
Drugs Don't Work! 30 Arbor Street Hartford, CT 06106 Telephone #: (860) 231-8311 Fax #: (860) 236-9412 Contact: Susan Patrick, President	Statewide
Department of Children and Families Training Academy 505 Hudson Street Hartford, CT 06106 Telephone #: (860) 550-6363 Fax #: (860) 550-6362 Web address: www.dcf.state.ct.us	Statewide
c) TECHNICAL ASSISTANCE AROUND ENSURING CULTURALLY RELEVANT PROGRAMMING…	
CT Institute for Cultural Literacy & Wellness 60 Connolly Parkway Building 12-101 Hamden, CT 06514 Telephone #: (203) 281-1347 Web address: www.freeweb.com Contact: Gloria Austin, Executive Director Email address: ciclw@freewwweb.com	Statewide

d) TECHNICAL ASSISTANCE ON STRENGTH-BASED PREVENTION MODELS…	
RESOURCES	**AREAS COVERED**
Connecticut Assets Network 465 Silas Deane Highway Wethersfield, CT 06109-2171 Telephone #: (860) 571-8463 Toll Free #: (800) 991-8463 Fax #: (860) 571-8465 Email address: ryan@ctassets.org	Statewide

e) PLANNING, COORDINATION & RESOURCE DEVELOPMENT…	
Lower Fairfield County Action Against Chemical Dependency Franklin Commons – 141 Franklin Street Stamford, CT 06901 Telephone #: (203) 978-1881 Fax #: (203) 327-3072 Email address: judeo@att.net	Region IA Darien, Greenwich, Stamford, New Canaan
Mid-Fairfield Substance Abuse Coalition c/o Human Services Council of Mid-Fairfield 83 East Avenue, Suite 307 Norwalk, CT 06851 Telephone #: (203) 852-0850 Fax #: (203) 852-9357 Email address: HSC@SNET.net	Region IB Norwalk, Weston, Westport, Wilton
Regional Youth/Adult Substance Abuse Project c/o United Way of Eastern Fairfield County 75 Washington Avenue Bridgeport, CT 06604 Telephone #: (203) 333-3333 Fax #: (203) 333-9118 Email address: rfrancis_99@yahoo.com	Region IC Bridgeport, Easton, Fairfield, Trumbull, Monroe, Stratford
Meriden & Wallingford Substance Abuse Council, Inc. 5 Brookside Drive, PO Box 307 Wallingford, CT 06492 Telephone #: (203) 294-3591 Fax #: (203) 294-3593 Email address: MBFMCG@aol.com	Region IIA Meriden, Wallingford
Greater New Haven Development State c/o Community Foundation for Greater New Haven	Region IIB Bethany, Milford, Branford, East Haven, Guilford, Hamden, Madison, Woodbridge, New Haven, North Branford, Orange, West Haven

e) PLANNING, COORDINATION & RESOURCE DEVELOPMENT… *(cont'd)*

RESOURCE	AREAS COVERED
Birmingham Group Health Services 435 East Main Street Ansonia, CT 06401 Telephone #: (203) 736-8566 Fax #: (203) 736-2641 Email address: vsaac@aol.com	Region IIC Ansonia, Derby, Seymour, Oxford, Shelton
Business/Industry Foundation of Middlesex County 393 Main Street Middletown, CT 60457 Telephone #: (203) 347-5959 Fax #: (203) 346-1043 Email address: mcsaac@connix.com	Region IID Essex, Portland, Chester, Cromwell, East Hampton, Old Saybrook, Westbrook, Killingworth, Middlefield, Clinton, Deep River, Durham, East Haddam
Northeast Communities Against Substance Abuse 303 Putnam Road (Route 12) – PO Box 167 Wauregan, CT 06387 Telephone #: (860) 564-7771 Fax #: (860) 564-7855 Email address: necasa@snet.net	Region IIIA Ashford, Brooklyn, Canterbury, Chaplin, columbia, Coventry, Eastford, Hampton, Killingly, Lebanon, Mansfield, Woodstock, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Wauregan, Willington, Windham
Citizen's Task Force on Substance Abuse in New London County 125 Shaw Street, Suite 117 New London, CT 06320 Telephone #: (860) 442-1330 Fax #: (860) 444-0759 Email address: CTTASK@aol.com	Region IIB Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Ledyard, Lisbon, Lyme, Montville, New London, North Stonington, Norwich, Old Lyme, Preston, Salem, Sprague, Stonington, Voluntown, Waterford
East of the River Action for Substance Abuse Elimination 70 Canterbury Street East Hartford, CT 06118 Telephone #: (860) 568-4442 Fax #: (860) 568-4445 Email address: ERASE@snet.net	Region IVA Hebron, Bolton, East Hartford, East Windsor, Ellington, Enfield, Glastonbury, Vernon, Andover, Manchester, Marlborough, Somers, South Windsor, Stafford, Tolland
Capitol Area Substance Abuse Council 776 Farmington Avenue West Hartford, CT 06119 Telephone #: (860) 586-8838 Fax #: (860) 586-8834 Email address: Lorizehe@concentric.net	Region IVB Avon, Bloomfield, Canton, Hartland, Newington, Rocky Hill, Suffield, West Hartford, Windsor Locks, East Granby, Windsor, Farmington, Simsbury, Granby, Wethersfield

e) PLANNING, COORDINATION & RESOURCE DEVELOPMENT… *(cont'd)*

RESOURCE	AREAS COVERED
Regional Substance Abuse Action Council of Central CT, Inc. 7 North Washington Street – Suite 103 Plainville, CT 06062 Telephone #: (860) 793-1830 or (800) 253-2756 Fax #: (860) 793-7807 Email address: nelson.forman@ctprevention.com saac@ctprevention.com SAAC1@AOL.com	Region IVC Berlin, Bristol, Burlington, Plainville, Plymouth, Southington, New Britain
Housatonic Valley Coalition 304 Federal Road – Suite 104 Brookfield, CT 06804 Telephone #: (203) 775-4083 Fax #: (203) 775-4613 Email address: housatonic.valley@snet.net	Region VA Bethel, Bridgewater, Brookfield, Danbury, Sherman, New Milford, New Fairfield, Newtown, Redding, Ridgefield, Roxbury, Washington
City of Waterbury/Workforce Connection 30B Church Street Waterbury, CT 06702 Telephone #: (203) 753-8211 Fax #: (203) 755-8009 **(No E-Mail Address available at this time)**	Region VB Beacon Falls, Thomaston, Waterbury, Watertown, Wolcott, Woodbury, Southbury, Bethelehem, Cheshire, Middlebury, Naugatuck, Prospect

FOR FURTHER INFORMATION CONTACT THE FOLLOWING STATE AGENCIES…

Department of Children & Families 505 Hudson Street Hartford, CT 06106 Telephone #: (860) 550-6527 Contact: DeAnna Paugas	Department of Education 165 Capitol Avenue Hartford, CT 06106 Telephone #: (860) 566-6645 Contact: Nancy Pugliese	Department of Public Health 410 Capitol Avenue, MS#13COM Hartford, CT 06106 Telephone #: (860) 509-7832 Contact: Beth Weinstein
Department of Social Services 25 Sigourney Street Hartford, CT 06106 Telephone #: (860) 424-5872 Contact: Joseph Freyre	Department of Transportation 2800 Berlin Turnpike Newington, CT 06111 Telephone #: (860) 594-2363 Contact: Sue Maloney	Judicial Department/Alternative Sanctions Court Svcs. Support Div. Judicial Branch 2275 Silas Deane Highway Rocky Hill, CT 06067 Telephone #: (860) 721-0936 Contact: Kathy Foley-Geib
Office of Policy & Management 450 Capitol Avenue Hartford, CT 06106 Telephone #: (860) 418-6292 Contact: Joan Hubbard	Department of Mental Health & Addiction Services 410 Capitol Avenue, MS#14PIT Hartford, CT 06134 Telephone #: (860) 418-6660 Contact: SIG Info-Line	

WEBSITES

STATE LEVEL	NATIONAL
Department of Mental Health and Addiction Services Address: www.dmhas.state.ct.us Department of Public Health Address: www.dfh.state.ct.us Department of Transportation Address: www.dot.state.ct.us Department of Social Services Address: www.dss.state.ct.us Department of Children and Families Address: www.dcf.state.ct.us Department of Education Address: www.doe.state.ct.us Judicial Branch www.jud.state.ct.us Office of Policy Management Address: www.opm.state.ct.us	Center for Substance Abuse Prevention (CSAP) Address: www.covsoft.com/csap Department of Health and Human Services Address: www.os.dhhs.gov Join Together Address: www.jointogether.org National Association of State Alcohol and Drug Abuse Director (NIDA) Address: www.nasadad.org National Clearinghouse for Alcohol and Drug Information (NCADI-Preveline) Address: www.health.org National Institute of Health Address: www.nih.gov Substance Abuse and Mental Health Services (SAMHSA) Address: www.samsha.gov

REGIONAL	
The Northeast Center for the Application of Prevention Technology (CAPT) Address: www.edc.org/capt Regional Alcohol and Drug Awareness Resources (RADAR) Address: www.radarnet.org	

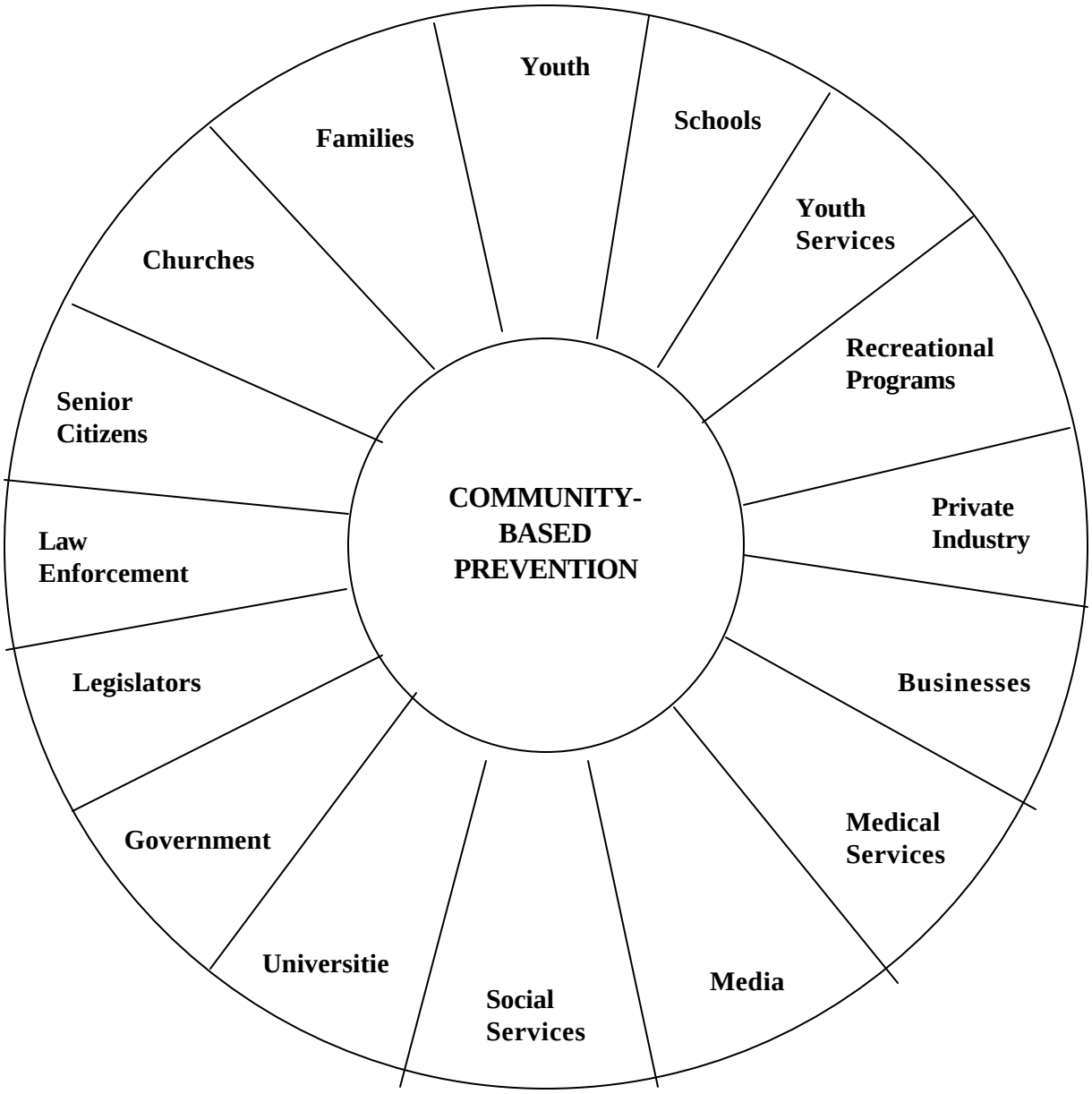
APPENDIX K

RECOMMENDED COLLABORATORS

RECOMMENDED COLLABORATORS

Collaborative community-wide efforts are essential in creating positive supportive and nurturing environments that will discourage alcohol, tobacco and other drug (ATOD) use. There is increasing recognition that ATOD use and other social problems like teen pregnancy, child abuse delinquency, school failure, youth suicide and violence share common roots that lie in the community. Responsibility for addressing these problems therefore falls on the community as a whole and the institutions within these communities identified in the figure below. Ideally, community prevention includes collaboration from all segments of the community and increases the likelihood of whole systems change.

In addition to the entities identified in the wheel of community systems (below), a list of collaborators are attached. Applicants are encouraged to involve these as well as all sectors identified in the wheel. Involvement of these systems increases the likelihood that problems will be addressed at their source.



Source: The Prevention Forum, April 1989. Bonnie Bernard "Working Together: Principles of Effective Collaboration." Bonnie's Prevention Corner.

RECOMMENDED COLLABORATORS *(cont'd)*

NAME	ADDRESS
Resource Links	
Connecticut Clearinghouse	334 Farmington Avenue Plainville, CT 06062 Telephone: (860) 793-9791 or (800) 232-4424 Fax: (860) 793-9813
The CENTER	111 Founders Plaza – 12th Floor East Hartford, CT 06108 Telephone: (860) 610-4646 or (800) 441-9926 Fax: (860) 610-4647
Drugs Don't Work!	30 Arbor Street Hartford, CT 06106 Telephone: (860) 231-8311 Fax: (860) 236-9412
Connecticut Assets Network	465 Silas Deane Highway Wethersfield, CT 06109-2171 Telephone: (860) 571-8463 or (800) 991-8463 Fax: (860) 571-8465
Connecticut Institute for Cultural Literacy & Wellness	60 Connolly Parkway – Bldg. 12 – Suite 101 Hamden, CT 06514 Telephone: (203) 281-1347 Fax: (203) 281-1386
Regional Action Councils	
Lower Fairfield County Action Against Chemical Dependency	Franklin Commons – 141 Franklin Street Stamford, CT 06901 Telephone #: (203) 978-1881 Fax #: (203) 327-3072 Email address: judeo@att.net
Mid-Fairfield Substance Abuse Coalition	c/o Human Services Council of Mid-Fairfield 83 East Avenue, Suite 307 Norwalk, CT 06851 Telephone #: (203) 852-0850 Fax #: (203) 852-9357 Email address: HSC@SNET.net
Regional Youth/Adult Substance Abuse Project	c/o United Way of Eastern Fairfield County 75 Washington Avenue Bridgeport, CT 06604 Telephone #: (203) 333-3333 Fax #: (203) 333-9118 Email address: rfrancis_99@yahoo.com
Meriden & Wallingford Substance Abuse Council, Inc.	5 Brookside Drive, PO Box 307 Wallingford, CT 06492 Telephone #: (203) 294-3591 Fax #: (203) 294-3593 Email address: MBFMCG@aol.com
Birmingham Group Health Services	435 East Main Street Ansonia, CT 06401 Telephone #: (203) 736-8566 Fax #: (203) 736-2641 Email address: vsaac@aol.com

Business/Industry Foundation of Middlesex County	393 Main Street Middletown, CT 60457 Telephone #: (203) 347-5959 Fax #: (203) 346-1043 Email address: mcsaac@connix.com
Northeast Communities Against Substance Abuse	303 Putnam Road (Route 12) – PO Box 167 Wauregan, CT 06387 Telephone #: (860) 564-7771 Fax #: (860) 564-7855 Email address: necasa@snet.net
Citizen's Task Force on Substance Abuse in New London County	125 Shaw Street, Suite 117 New London, CT 06320 Telephone #: (860) 442-1330 Fax #: (860) 444-0759 Email address: CTTASK@aol.com
East of the River Action for Substance Abuse Elimination	70 Canterbury Street East Hartford, CT 06118 Telephone #: (860) 568-4442 Fax #: (860) 568-4445 Email address: ERASE@snet.net
Capitol Area Substance Abuse Council	776 Farmington Avenue West Hartford, CT 06119 Telephone #: (860) 586-8838 Fax #: (860) 586-8834 Email address: Lorizehe@concentric.net
Regional Subustance Abuse Action Council of Central CT, Inc.	7 North Washington Street – Suite 103 Plainville, CT 06062 Telephone #: (860) 793-1830 or (800) 253-2756 Fax #: (860) 793-7807 Email address: nelson.forman@ctprevention.com saac@ctprevention.com SAAC1@AOL.com
Housatonic Valley Coalition	304 Federal Road – Suite 104 Brookfield, CT 06804 Telephone #: (203) 775-4083 Fax #: (203) 775-4613 Email address: housatonic.valley@snet.net
City of Waterbury/Workforce Connection	30B Church Street Waterbury, CT 06702 Telephone #: (203) 753-8211 Fax #: (203) 755-8009 **(No E-Mail Address available at this time)**

Local Prevention Councils

Contact the RAC Directors listed above or the
Department of Mental Health & Addiction Services
(860) 418-6660

Directors of Community Services – Department of Children & Families	
Southwest Region	3883 Main Street Bridgeport, CT 06606 Contact: Diane Appel Telephone: (203) 365-6346 Fax: (203) 374-2663

South Central Region	One Long Wharf New Haven, CT 06511 Contact: Pat Weel Telephone: (203) 786-3303 Fax: (203) 777-4317
North Central Region	250 Hamilton Street Hartford, CT 06106 Contact: Nellie Cartagena Telephone: (860) 418-8308 Fax: (860) 418-8323
Northwest Region	395 West Main Street Waterbury, CT 06702 Contact: Wayne Kames Telephone: (203) 759-7268 Fax: (203) 759-7296
Eastern Region	2 Courthouse Square Norwich, CT 06360 Contact: Gene Marchand Telephone: (860) 885-2478 Fax: (860) 885-1300

APPENDIX L

APPLICATION REVIEW FORMAT

GOVERNOR'S PREVENTION INITIATIVE FOR YOUTH
APPLICATION REVIEW FORMAT

Applicant Name:	Overall Score:
Requested Amount:	Reviewer:

LEVEL 1 REVIEW – MINIMUM REQUIREMENTS

a. Completeness of Application ***(The following are completed and included in proposal).***

	Yes	No	Comments
▪ Face Page			
▪ Table of Content			
▪ Abstract			
▪ Logic Model Grid			
▪ Table of Organization			
▪ Community Readiness Worksheet			
▪ Budget and Justification			
▪ Program Narrative			
▪ Signed Assurances			
▪ Appendices			

b. Compliance with Submission ***(The following requirements have been met).***

	Yes	No	Comments
▪ 8 ½ x 11 paper used			
▪ Single spacing			
▪ 1 inch margins			
▪ 12 pitch font size			
▪ Applicant's name in upper right hand corner or each page of proposal			
▪ Pages are numbered consecutively from beginning to end			

c. Eligibility Met? ***(Applicant is:)***

	Yes	No	Comments
▪ Non-profit or for-profit organization?			
▪ Single agency, coalition or consortium?			

Applications indicating "no" on any of the above items will be deemed incomplete or ineligible and removed from further review.

Has above applicant met minimum requirements? ❑ Yes ❑ No

LEVEL 2 REVIEW – TECHNICAL MERIT

Scoring Scale:

0 1 2 3 4 5

Has not met criteria *Met and/or surpassed criteria*

a. Realistic and measurable goals and objectives. ▪ Application demonstrates understanding of RFP's goals & objectives (1) ▪ Goals & objectives consistent with those in the RFP (1) ▪ Goals & objectives realistic and measurable (1) ▪ Soundness of Implementation Plan (2)	_____ x __1__ = _____ score weight total	Comments:
b. Extent to which project uses science-based prevention. ▪ use of science-based prevention model (levels 3,4,5)	_____ x __7__ = _____	
▪ incorporation of prevention principles	_____ x __3__ = _____	
▪ innovative programs (levels 1,2)	_____ x __1__ = _____	
c. Use of needs assessment for defined community. ▪ legitimate data sources: (1) ▪ inclusion of target population: (1) ▪ clear identification of needs/gaps for target population: (3)	_____ x __1__ = _____	

d. Appropriate program components/strategies to realize objectives. ▪ Multiple strategies (1) ▪ Developmentally appropriate to target population (1) ▪ Breadth & scope of project adequate to achieve outcomes (1) ▪ Culturally appropriate to target population, i.e. staffing, standards, language & training (1) ▪ Appropriately addresses target population categories of the IOM (1)	_____ x __1__ = _____ score weight total	Comments:
e. Use of the Logic Model. ▪ Logical and clearly defined relationship between risk & protective factors being addressed; selected strategies and desired outcomes (5)	_____ x __1__ = _____	
f. Management & Staffing Plan/Workplan. ▪ Clear description of how project will be managed (2) ▪ Roles and responsibilities of project staff clear (2) ▪ Staff have appropriate qualifications and experience (1)	_____ x __1__ = _____	
g. Clear and detailed budget. ▪ Realistic; well-justified budget (2) ▪ In-kind funding 1 included (1) ▪ Cash match included (2)	_____ x __1__ = _____	
h. Attention to evaluation. ▪ Demonstrated understanding of evaluation process for grant (2) ▪ Letter of collaboration from school system included (2) ▪ Sufficient resources allocated for evaluation activities (1)	_____ x __1__ = _____	

TOTAL SCORE – LEVEL 2 TECHNICAL MERIT:

LEVEL 3 - ADDITIONAL CRITERIA		
a. Applicants prevention experience and organizational capacity. ▪ Applicant has extensive experience in managing projects of this size. ▪ Applicant has performed well on existing or previous state contracts.	_____ Score 1-5	Comments:
b. Support for Project. ▪ Coalition/consortium contains diverse community stakeholders ▪ Application reflects collaborations with stakeholders ▪ Letters of commitment included ▪ Application contains sustainability plan	_____ Score 1-5	Comments:

TOTAL SCORE – LEVEL 3 – ADDITIONAL CRITERIA:

TOTAL OVERALL SCORE:

T:\Prevent\SIG\SIGAPP~1.doc

APPENDIX M

GLOSSARY OF TERMS

GLOSSARY OF TERMS

ATOD: Alcohol, Tobacco and Other Drugs

ADPC: The Alcohol and Drug Policy Council. A statutory body that was established in 1996, under Public Act 97-248 charged with setting the direction for statewide substance abuse programs and services.

Aggregate Data: Refers to data, which represent Connecticut as a whole, but do not necessarily represent any town, region or geographic area within the state. Aggregate data present a statewide average, and are distinct from "local" data which are true for individual local communities, towns or other geographic areas within the state.

Baseline: The status of a group or population that exists prior to any intervention; used as a reference point against which future change will be compared.

Center for the Application of Prevention Technology (CAPT): An organization selected by CSAP to serve as a regional source of technical assistance on the application of science-based prevention at the state and community level.

Coalition: A structured arrangement for cooperation and collaboration between otherwise unrelated groups or organizations in which each group retains its identity, but all agree to work together toward a common, mutually agreed upon goal.

Collaboration: A process to reach goals that cannot be achieved acting singly (or at a minimum, cannot be reached as efficiently). As a process, collaboration is a means to an end, not an end in itself. The desired end is more comprehensive and appropriate prevention services that improve prevention outcomes.

Center for Substance Abuse Prevention (CSAP): The federal funding source for the State Incentive Grant, and a division of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Domain: The spheres of influence in a person's life in which a risk factor or prevention opportunity might occur, namely, community, family, school, peer and individual.

Effective: Preponderance of research or program findings is consistent, positive, and clearly related to the intervention.

Evaluation Research: A set of procedures to determine the effectiveness of a prevention/intervention program.

Goal: A goal is a broad, general statement concerning what a program intends to accomplish..

Illicit drugs: Drugs and chemicals that have been expressly defined as illegal to possess, use, handle or sell without special permit.

Intervention: Any action or coordinated group of actions taken for the purpose of changing a condition from its existing status to a more desirable status.

Objective: A specific statement describing what will be accomplished, by whom, for whom, and how success will be measured.

Principle: A lesson learned from experience and published in the literature; a theoretical basis for planning effective strategies.

Program: A collection of strategies put together to create a meaningful whole; also referred to as an intervention.

Protective Factors: Characteristics and processes that may help protect or provide a buffer for a person from problems such as substance use/abuse, and can strengthen their determination to reject use of alcohol, tobacco and other drugs. Also referred to as "assets" (as in "asset" development program).

Refereed Journal: A professional journal which, as standard operating procedure, requires all manuscripts submitted for publication to be reviewed and critiqued by a group of the author's professional "peers" before the manuscript is published as an article. This procedure is used to protect, maintain and ensure the quality of scholarly material the journal publishes. The fact that a journal is peer-reviewed is geneally provided by the journal's publisher and is sometimes noted on library indices of scholarly and professional journals.

Replication: Repeating the exact procedure used in a program to determine whether the same results are obtained. Programs can be replicated exactly or principles derived from programs can be replicated conceptually. Exact replications simply apply the original program to a new population or new locality. Conceptual replications adapt the program, maintaing its key principles but modifying specific activities.

Resiliency: Elements of personality and temperament, as well as a positive life skills and experiences, that help a person succeed despite growing up in a high-risk environment.

Risk Factors: Characteristics or attributes of a person, their family, their peers, their environment, their school, etc. that have been associated with a higher susceptibility to alcohol and other drug use and other problems.

Science-Based Prevention Strategies: Prevention actions, and products that have been evaluated and have been shown to have an effect on actual substance use, norms related to use, or specific risk factors that have been linked to substance use. Prevention interventions are considered to be based in science if they meet three conditions:

- The intervention has been demonstrated to positively affect tobacco, alcohol an illicit drug use as well as the problems, risk factors and protective factors related to use;
- Research results have been published by a peer-reviewed journal or have undergone equivalent scientific review;
- The interventions have instruments; protocols and other relevant materials available to be used in replications.

Setting: The place in which a prevention strategy or program takes place, i.e. home, school, workplace, public places, etc.

SIG: State Incentive Grant of Connecticut; the Governor's Prevention Youth Initiative.

Strategy: A course of action; an individual component of a program intervention, or something one does to put principles into practice. Six science-based strategies include: information dissemination, education, social

policy/environmental change, substance-free recreation, problem identification and referral/early intervention, and community organization and development.

Target Population: The population, or particular portion of a population, that an applicant intends to affect (improve) with the applicant's proposed project.

Validity: The "truthfulness" of a measure; a valid measure is one that measures what it claims to measure.